

		FOR OFF USE					

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2005
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2005)

IMPORTANT NOTICE
 THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

<p>I. IDPH Facility ID Number: <u>0039644</u></p> <p>Facility Name: <u>Caseyville Nursing & Rehabilitation Center</u></p> <p>Address: <u>601 West Lincoln Avenue</u> <u>Caseyville</u> <u>62232</u> Number City Zip Code</p> <p>County: <u>St. Clair</u></p> <p>Telephone Number: <u>(618) 345-3072</u> Fax # <u>(618) 345-3170</u></p> <p>IDPA ID Number: <u>363952446001</u></p> <p>Date of Initial License for Current Owners: <u>06/01/1994</u></p> <p>Type of Ownership:</p> <table style="width: 100%;"> <tr> <td><input type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td><input checked="" type="checkbox"/> PROPRIETARY</td> <td><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td><input type="checkbox"/> Charitable Corp.</td> <td><input type="checkbox"/> Individual</td> <td><input type="checkbox"/> State</td> </tr> <tr> <td><input type="checkbox"/> Trust</td> <td><input type="checkbox"/> Partnership</td> <td><input type="checkbox"/> County</td> </tr> <tr> <td>IRS Exemption Code _____</td> <td><input type="checkbox"/> Corporation</td> <td><input type="checkbox"/> Other _____</td> </tr> <tr> <td></td> <td><input checked="" type="checkbox"/> "Sub-S" Corp.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Limited Liability Co.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Trust</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Other _____</td> <td></td> </tr> </table> <p>In the event there are further questions about this report, please contact: Name: <u>Charles J. Fischer</u> Telephone Number: <u>(312) 634-4580</u> Please send copies of desk review and audit adjustments to address on this page</p>	<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL	<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State	<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County	IRS Exemption Code _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____		<input checked="" type="checkbox"/> "Sub-S" Corp.			<input type="checkbox"/> Limited Liability Co.			<input type="checkbox"/> Trust			<input type="checkbox"/> Other _____		<p>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/2005</u> to <u>12/31/2005</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table style="width: 100%;"> <tr> <td style="width: 30%;">Officer or Administrator of Provider</td> <td>(Signed) _____ (Type or Print Name) _____ (Date) _____</td> </tr> <tr> <td>Paid Preparer</td> <td>(Signed) <u>SEE ACCOUNTANTS' COMPILATION REPORT</u> (Date) _____</td> </tr> <tr> <td></td> <td>(Print Name and Title) _____</td> </tr> <tr> <td></td> <td>(Firm Name & Address) <u>Altschuler, Melvoin and Glasser LLI</u> <u>One South Wacker Drive, Suite 800, Chicago, IL 60606</u></td> </tr> <tr> <td></td> <td>(Telephone) <u>(312) 384-6000</u> Fax # <u>(312) 634-5518</u></td> </tr> <tr> <td colspan="2"> MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630 </td> </tr> </table>	Officer or Administrator of Provider	(Signed) _____ (Type or Print Name) _____ (Date) _____	Paid Preparer	(Signed) <u>SEE ACCOUNTANTS' COMPILATION REPORT</u> (Date) _____		(Print Name and Title) _____		(Firm Name & Address) <u>Altschuler, Melvoin and Glasser LLI</u> <u>One South Wacker Drive, Suite 800, Chicago, IL 60606</u>		(Telephone) <u>(312) 384-6000</u> Fax # <u>(312) 634-5518</u>	MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630	
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SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Page 2

Facility Name & ID Number Caseyville Nursing & Rehabilitation Center# 0039644 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days,
(must agree with license). Date of change in licensed bedsN/A

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>150</u>	Skilled (SNF)	<u>150</u>	<u>54,750</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>150</u>	TOTALS	<u>150</u>	<u>54,750</u>	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	<u>1,160</u>	<u>980</u>	<u>3,330</u>	<u>5,470</u>	8
9	SNF/PED					9
10	ICF	<u>35,993</u>	<u>6,196</u>		<u>42,189</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>37,153</u>	<u>7,176</u>	<u>3,330</u>	<u>47,659</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed
bed days on line 7, column 4.) 87.05%

D. How many bed-hold days during this year were paid by the Department?

None (Do not include bed-hold days in Section B.)E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)None

F. Does the facility maintain a daily midnight census?

YesG. Do pages 3 & 4 include expenses for services or
investments not directly related to patient care?YES ☒NO ☐Non-allowable costs have been
eliminated in Schedule V, Column 7.

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES ☐NO ☒

I. On what date did you start providing long term care at this location

Date started 06/01/1994

J. Was the facility purchased or leased after January 1, 1978?

YES ☒Date 06/01/1994NO ☐

K. Was the facility certified for Medicare during the reporting year?

YES ☒NO ☐

If YES, enter number

of beds certified 30 and days of care provided 3,330Medicare Intermediary Mutual of Omaha

IV. ACCOUNTING BASIS

ACCRUAL ☒ MODIFIED
CASH* ☐ CASH* ☐Is your fiscal year identical to your tax year YES ☒ NO ☐Tax Year: 12/31/05 Fiscal Year: 12/31/05

* All facilities other than governmental must report on the accrual basis

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Page 3

Facility Name & ID Number Caseyville Nursing & Rehabilitation Center # 0039644 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7**	Adjusted Total 8	FOR OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
A. General Services											
1	Dietary	206,609	14,835	9,652	231,096		231,096		231,096		1
2	Food Purchase		226,449		226,449		226,449	(5,827)	220,622		2
3	Housekeeping	120,612	73,703		194,315		194,315	280	194,595		3
4	Laundry	103,759	14,025		117,784		117,784		117,784		4
5	Heat and Other Utilities			131,943	131,943		131,943	1,993	133,936		5
6	Maintenance	97,326	38,591	6,260	142,177		142,177	621	142,798		6
7	Other (specify):*										7
8	TOTAL General Services	528,306	367,603	147,855	1,043,764		1,043,764	(2,933)	1,040,831		8
B. Health Care and Programs											
9	Medical Director			4,800	4,800		4,800		4,800		9
10	Nursing and Medical Records	1,616,230	20,872	4,200	1,641,302		1,641,302	(43)	1,641,259		10
10a	Therapy			615,585	615,585		615,585		615,585		10a
11	Activities	63,123	5,650		68,773		68,773		68,773		11
12	Social Services	43,946			43,946		43,946		43,946		12
13	CNA Training										13
14	Program Transportation			206	206		206		206		14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,723,299	26,522	624,791	2,374,612		2,374,612	(43)	2,374,569		16
C. General Administration											
17	Administrative	81,645		243,250	324,895		324,895	(132,929)	191,966		17
18	Directors Fees										18
19	Professional Services			61,159	61,159		61,159	7,006	68,165		19
20	Dues, Fees, Subscriptions & Promotion			4,296	4,296		4,296	62	4,358		20
21	Clerical & General Office Expense	278,339		24,289	302,628		302,628	67,728	370,356		21
22	Employee Benefits & Payroll Tax			365,866	365,866		365,866	3,968	369,834		22
23	Inservice Training & Education										23
24	Travel and Seminar			2,733	2,733		2,733	(2,048)	685		24
25	Other Admin. Staff Transportation			27,547	27,547		27,547	324	27,871		25
26	Insurance-Prop.Liab.Malpractice			39,555	39,555		39,555	15,563	55,118		26
27	Other (specify):* Mgt. Alloc-Benefits							14,920	14,920		27
28	TOTAL General Administration	359,984		768,695	1,128,679		1,128,679	(25,406)	1,103,273		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,611,589	394,125	1,541,341	4,547,055		4,547,055	(28,382)	4,518,673		29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

STATE OF ILLINOIS

Page 4

Facility Name & ID Number Caseyville Nursing & Rehabilitation Center #0039644 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7**	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			97,386	97,386		97,386	271,336	368,722			30
31	Amortization of Pre-Op. & Org											31
32	Interest			45,100	45,100		45,100	365,565	410,665			32
33	Real Estate Taxes							95,330	95,330			33
34	Rent-Facility & Grounds			720,000	720,000		720,000	(720,000)				34
35	Rent-Equipment & Vehicle			280	280		280	1,168	1,448			35
36	Other (specify): ^a Mortgage Insurance							31,739	31,739			36
37	TOTAL Ownership			862,766	862,766		862,766	45,138	907,904			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Center:		97,061	548	97,609		97,609		97,609			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shop											41
42	Provider Participation Fee			82,125	82,125		82,125		82,125			42
43	Other (specify): ^a Nonallowable Cost			32,698	32,698		32,698	(32,698)				43
44	TOTAL Special Cost Centers		97,061	115,371	212,432		212,432	(32,698)	179,734			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,611,589	491,186	2,519,478	5,622,253		5,622,253	(15,942)	5,606,311			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

**See Schedule of adjustments attached at end of cost report.

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Page 5

Facility Name & ID Number Caseyville Nursing & Rehabilitation Center

0039644

Report Period Beginning:

01/01/2005

Ending:

12/31/2005

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer-	OHF USE	
			ence	ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Program				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Room				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patient				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(29,452)	30		9
10	Interest and Other Investment Income	(14,186)	32		10
11	Discounts, Allowances, Rebates & Refund				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(496)	43		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transaction				15
16	Personal Expenses (Including Transportation				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainer	(795)	19		22
23	Malpractice Insurance for Individual				23
24	Bad Debt	(15,224)	43		24
25	Fund Raising, Advertising and Promotion	(108)	43		25
26	Income Taxes and Illinois Personal				26
27	Property Replacement Tax				27
28	CNA Training for Non-Employee				28
29	Yellow Page Advertising				29
29	Other-Attach Schedule See Schedule 5A	(64,561)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (124,822)		\$	30

OHF USE ONLY							
48		49		50		51	52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below. (See instructions.)

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule	\$		31
32	Donated Goods-Attach Schedule			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	108,880		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 108,880		36
37	(sum of SUBTOTALS (A) and (B))	\$ (15,942)		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1	2	3	4	
		Yes	No	Amount	Reference	
38	Medically Necessary Transport		x	\$		38
39						39
40	Gift and Coffee Shop		x			40
41	Barber and Beauty Shops		x			41
42	Laboratory and Radiology		x			42
43	Prescription Drugs		x			43
44	Exceptional Care Program		x			44
45	Other-Attach Schedule		x			45
46	Other-Attach Schedule		x			46
47	TOTAL (C): (sum of lines 38-46)			\$		47

SEE ACCOUNTANTS' COMPILATION REPORT

Caseyville Nursing & Rehabilitation Center

Provider #: 0039644

01/01/2005 to 12/31/2005

Schedule 5A

VI. Adjustment Detail

Line 29 - Other

Non-allowable expenses	Amount	Reference
Office Expense	(506)	21
Lab Expense - Med A	(9,172)	43
X-Ray Expense - Med A	(7,698)	43
Related Party Interest	(45,100)	32
Disallow out of state travel	<u>(2,085)</u>	24
	<u><u>(64,561)</u></u>	

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Page 5A

Caseyville Nursing & Rehabilitation CenterID# 0039644Report Period Beginning: 01/01/2005Ending: 12/31/2005

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference
1	Misc. - Part A	\$	1
2	Labs - Part A		2
3	X-Rays - Part A		3
4	Vending Machine Expense		4
5	Disallowed Non-Care Related Real Estate Tax		5
6			6
7			7
8			8
9			9
10			10
11			11
12			12
13			13
14			14
15			15
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36			36
37			37
38			38
39			39
40			40
41			41
42			42
43			43
44			44
45			45
46			46
47			47
48			48
49	Total	0	49

Summary A

12/31/2005

[illegible]

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Caseyville Nursing & Rehabilitation Center # 0039644 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	(29,452)	296,818	3,970	0	0	0	0	0	0	0	0	271,336	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(14,186)	423,390	1,461	0	0	0	0	0	0	0	0	410,665	32
33	Real Estate Taxes	0	91,745	3,585	0	0	0	0	0	0	0	0	95,330	33
34	Rent-Facility & Grounds	0	(720,000)	0	0	0	0	0	0	0	0	0	(720,000)	34
35	Rent-Equipment & Vehicles	0	0	1,168	0	0	0	0	0	0	0	0	1,168	35
36	Other (specify):*	0	32,238	0	0	0	0	0	0	0	0	0	32,238	36
37	TOTAL Ownership	(43,638)	124,191	10,184	0	0	0	0	0	0	0	0	90,737	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(15,828)	0	0	0	0	0	0	0	0	0	0	(15,828)	43
44	TOTAL Special Cost Centers	(15,828)	0	0	0	0	0	0	0	0	0	0	(15,828)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(60,261)	143,582	(32,658)	(2,044)	0	0	0	0	0	0	0	48,619	45

Facility Name & ID Number Caseyville Nursing & Rehabilitation Center # 0039644 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See Attached Schedule 6A		See Attached Schedule 6B	See Attached Schedule 6B			

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line		Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V	19	Professional Services	\$	Caseyville Property LLC	100.00%	\$ 5,000	\$ 5,000	1
2	V	26	Insurance		Caseyville Property LLC	100.00%	14,391	14,391	2
3	V	30	Depreciation		Caseyville Property LLC	100.00%	296,818	296,818	3
4	V	32	Interest		Caseyville Property LLC	100.00%	423,390	423,390	4
5	V	33	Real Estate Taxes		Caseyville Property LLC	100.00%	91,745	91,745	5
6	V	34	Rent	720,000	Caseyville Property LLC	100.00%		(720,000)	6
7	V	36	Mortgage Insurance		Caseyville Property LLC	100.00%	32,238	32,238	7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$ 720,000			\$ 863,582	\$ * 143,582	14

* Total must agree with the amount recorded on line 34 of Schedule VI

SEE ACCOUNTANTS' COMPILATION REPORT

Caseyville Nursing & Rehabilitation Center

Provider #: 0039644

01/01/2005 to 12/31/2005

Schedule 6B

VII Related Parties - Page 6

Related Nursing Homes

City

In-State:

Cahokia Nursing and Rehab	Cahokia
Caseyville Nursing and Rehab	Caseyville
Franklin Grove Nursing Center	Franklin Grove
Kenwood Healthcare Center	Chicago
Oregon Healthcare Center	Oregon
Shabbona Healthcare Center	Shabbona
Tower Hill Healthcare Center	South Elgin
Virgil Calvert Nursing and Rehab	East St. Louis

Out-of-State:

St. Elizabeth Healthcare Center	Florissant, MO
Hillside Manor Healthcare and Rehab	St. Louis, MO

Other Related Business Entities

S.W. Management Co.	Skokie	Bookkeeping/Management Company
S&E Medical Supply Co.	Skokie	Medical Supplies
* SFO Associates	Skokie	Finance Company
** Unity Hospice	Skokie	Hospice Services

* This entity only relates to Shabbona Healthcare Center, Franklin Grove Nursing Center, and Oregon Healthcare Center.

** Pages 6 and 8 are not required for this entity since there was no payment from the nursing homes to the related entity.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Caseyville Nursing & Rehabilitation Center

0039644

Report Period Beginning: 01/01/2005 Ending: 12/31/2005

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	2 Food	\$	S.W. Management Co.	100.00%	\$ (25)	\$ (25)
16	V	3 Housekeeping		S.W. Management Co.	100.00%	280	280
17	V	5 Heat and Other Utilities		S.W. Management Co.	100.00%	1,993	1,993
18	V	6 Maintenance		S.W. Management Co.	100.00%	621	621
19	V	17 Administrative	183,250	S.W. Management Co.	100.00%	50,321	(132,929)
20	V	19 Professional Services		S.W. Management Co.	100.00%	2,801	2,801
21	V	20 Dues, Fees, Subs & Promotions		S.W. Management Co.	100.00%	62	62
22	V	21 Clerical & General Office Expense		S.W. Management Co.	100.00%	67,902	67,902
23	V	24 Travel and Seminar		S.W. Management Co.	100.00%	37	37
24	V	25 Other Admin. Staff Transport		S.W. Management Co.	100.00%	324	324
25	V	26 Insurance-Prop.Liab.Malpractice		S.W. Management Co.	100.00%	1,172	1,172
26	V	27 Mgmt. Allocation of Benefits		S.W. Management Co.	100.00%	14,920	14,920
27	V	30 Depreciation		S.W. Management Co.	100.00%	3,970	3,970
28	V	32 Interest		S.W. Management Co.	100.00%	1,461	1,461
29	V	33 Real Estate Taxes		S.W. Management Co.	100.00%	3,585	3,585
30	V	35 Rent - Equipment & Vehicles		S.W. Management Co.	100.00%	1,168	1,168
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 183,250			\$ 150,592	\$ * (32,658)

* Total must agree with the amount recorded on line 34 of Schedule V1

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Caseyville Nursing & Rehabilitation Center

0039644

Report Period Beginning: 01/01/2005 Ending: 12/31/2005

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	2 Food	\$ 10,055	S & E Medical Supply Co.	100.00%	\$ 8,054	\$ (2,001)	15
16	V	3 Housekeeping	3,558	S & E Medical Supply Co.	100.00%	3,558		16
17	V	10 Medical Supplies	5,158	S & E Medical Supply Co.	100.00%	5,115	(43)	17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$ 18,771			\$ 16,727	\$ * (2,044)	39

* Total must agree with the amount recorded on line 34 of Schedule V1

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Caseyville Nursing & Rehabilitation Center # 0039644 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Sheldon Wolfe	President	Administrative	23.67	See Schedule 7A	3	7.00	Salary	\$ 50,321	L17,C7	1
2	Ronnie Klein	COO	Administrative	5.00	See Schedule 7B	3.5	8.75	Salary&Fees	65,250	17,3 & 21,7	2
3	Moshe Herman	CFO	Administrative	0.67	See Schedule 7C	4.2	9.50	Salary	15,579	L21,C7	3
4											4
5											5
6											6
7	Note: All individuals work in excess of 40 hours per week										7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 131,150		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Caseyville Nursing & Rehabilitation Center # 0039644 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

Name of Related Organization S.W. Management Co.
 Street Address 7434 N. Skokie Blvd.
 City / State / Zip Code Skokie, IL 60077
 Phone Number (847) 982-2300
 Fax Number (847) 982-2304

B. Show the allocation of costs below. If necessary, please attach worksheets

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	2	Food	Bed Days Available	570,112	10	\$ (257)	\$	54,750	(25)	1
2	3	Housekeeping	Bed Days Available	570,112	10	2,912		54,750	280	2
3	5	Heat and Other Utilities	Bed Days Available	570,112	10	20,748		54,750	1,993	3
4	6	Maintenance	Bed Days Available	570,112	10	6,462		54,750	621	4
5	19	Professional Services	Bed Days Available	570,112	10	29,160		54,750	2,801	5
6	20	Dues, Fees, Subs & Promotions	Bed Days Available	570,112	10	640		54,750	62	6
7	21	Clerical & General Office Exp	Bed Days Available	570,112	10	652,396	606,507	54,750	62,652	7
8	24	Travel and Seminar	Bed Days Available	570,112	10	384		54,750	37	8
9	25	Other Admin. Staff Transport	Bed Days Available	570,112	10	3,378		54,750	324	9
10	26	Insurance-Prop., Liab. & Malp.	Bed Days Available	570,112	10	12,203		54,750	1,172	10
11	27	Mgmt. Allocation of Benefits	Bed Days Available	570,112	10	155,361		54,750	14,920	11
12	32	Interest	Bed Days Available	570,112	10	15,217		54,750	1,461	12
13	33	Real Estate Taxes	Bed Days Available	570,112	10	37,335		54,750	3,585	13
14	35	Rent - Equipment & Vehicles	Bed Days Available	570,112	10	12,167		54,750	1,168	14
15										15
16	17	Administrative	Avg. Hours Worked	44	10	738,036	738,036	3	50,321	16
17	21	Clerical & General Office Exp	Avg. Hours Worked	40	7	60,000	60,000	4	5,250	17
18										18
19	30	Depreciation	Direct Cost						3,970	19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 1,746,142	\$ 1,404,543		\$ 150,592	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Caseyville Nursing & Rehabilitation Center # 0039644 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

Name of Related Organization S & E Medical Supply Co.
 Street Address 3100 Commercial Avenue
 City / State / Zip Code Northbrook, IL 60062
 Phone Number (847) 982-9300
 Fax Number ()

B. Show the allocation of costs below. If necessary, please attach worksheets

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	2	Food	Direct Cost		\$	\$		8,054	1
2	3	Housekeeping	Direct Cost					3,558	2
3	10	Medical Supplies	Direct Cost					5,115	3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		16,727	25

SEE ACCOUNTANTS' COMPILATION REPORT

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related Long-Term												
1	Heartland Bank		X	Mortgage	\$38,896.00	11/27/01	\$ 6,814,400	\$ 6,583,462	12/01/36	0.0635	\$ 418,606	1	
2												2	
3												3	
4												4	
5												5	
	Working Capital												
6	N/P - Stockholders	X		Working Capital				721,963	Demand	Variable	36,578	6	
7	Intercompany Loan	X		Working Capital					Demand	0.0600	8,522	7	
8												8	
9	TOTAL Facility Related				\$38,896.00		\$ 6,814,400	\$ 7,305,425			\$ 463,706	9	
	B. Non-Facility Related*												
10							Interest income offset				(14,186)	10	
11							Amortization of mortgage costs				4,784	11	
12							Related Party Interest				(45,100)	12	
13							SW Management Allocation - Mortgage				1,461	13	
14	TOTAL Non-Facility Related						\$	\$			\$ (53,041)	14	
15	TOTALS (line 9+line14)						\$ 6,814,400	\$ 7,305,425			\$ 410,665	15	

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 31,739 Line # 36

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7
(See instructions.) SEE ACCOUNTANTS' COMPILATION REPORT

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.
(See instructions.)

Facility Name & ID Number **Caseyville Nursing & Rehabilitation Center**# **0039644** Report Period Beginning: **01/01/2005** Ending: **12/31/2005****IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)****B. Real Estate Taxes**

1. Real Estate Tax accrual used on 2004 report.		Important , please see the next worksheet, "RE_Tax". The real estate tax statement and t must accompany the cost report	\$	80,000	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		2004	\$	84,745	2
3. Under or (over) accrual (line 2 minus line 1).			\$	4,745	3
4. Real Estate Tax accrual used for 2005 report. (Detail and explain your calculation of this accrual on the lines below.)			\$	87,000	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)			\$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund.		Allocation from Management Company		3,585	
TOTAL REFUND \$ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)			\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru			\$	95,330	7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:		2000	65,232	8	
		2001	71,322	9	
		2002	73,113	10	
		2003	77,291	11	
		2004	84,745	12	
2004 tax bill: 84,745					
x 1.03					
87,287					
Use: 87,000					

FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2004 \$	13
14	PLUS APPEAL COST FROM LINE 5 \$	14
15	LESS REFUND FROM LINE 6 \$	15
16	AMOUNT TO USE FOR RATE CALCULATION\$	16

NOTES:

1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed

SEE ACCOUNTANTS' COMPILATION REPORT

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2004 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2004 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2004.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2004 real estate tax bill to the Department of Public Aid, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2005 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2004 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Caseyville Nursing & Rehabilitation Center COUNTY St. Clair

FACILITY IDPH LICENSE NUMBER 0039644

CONTACT PERSON REGARDING THIS REPORT Sheldon Wolfe

TELEPHONE (847) 982-2300 FAX #: (847) 982-2304

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2004 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2004.

(A)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1. <u>03-07.0-300-005</u>	<u>Long-term care property</u>	\$ <u>84,745.00</u>	\$ <u>84,745.00</u>
2. <u>10-28-412-049-0000</u>	<u>SW Management Allocation</u>	\$ <u>38,709.00</u>	\$ <u>3,585.00</u>
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>123,454.00</u>	\$ <u>88,330.00</u>

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home.
(Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the original 2004 tax bills which were listed in Section A to this statement. Be sure to use the 2004 tax bill which is normally paid during 2005.

SEE ACCOUNTANTS' COMPILATION REPORT

Caseyville Nursing & Rehabilitation Center**Provider #: 0039644****01/01/2005 to 12/31/2005****Schedule 10A****Allocation of Real Estate Tax Bill****S.W. Management Co.****Page 10, Line 2**

Facility Name/ Real Estate Tax #	Basis of Allocation	Available Patient Days	% Allocated	Amount Allocated
10-28-412-049-0000				\$ 38,709
% Applicable to Long Term Care:	Home Office/Management Fee			<u>96.45%</u>
				<u>\$ 37,335</u>
Cahokia Nursing and Rehab	Available Patient Days	54,750	9.60%	3,585
Caseyville Nursing and Rehab	Available Patient Days	54,750	9.60%	3,585
Franklin Grove Nursing Center	Available Patient Days	44,165	7.75%	2,892
Hillside Manor Healthcare and Rehab	Available Patient Days	44,512	7.81%	2,915
Kenwood Healthcare Center	Available Patient Days	116,070	20.36%	7,601
Oregon Healthcare Center	Available Patient Days	37,960	6.66%	2,486
Shabbona Healthcare Center	Available Patient Days	33,215	5.83%	2,175
St. Elizabeth Healthcare Center	Available Patient Days	54,750	9.60%	3,585
Tower Hill Healthcare Center	Available Patient Days	75,190	13.19%	4,924
Virgil Calvert Nursing and Rehab	Available Patient Days	54,750	9.60%	3,585
		<u>570,112</u>	<u>100.00%</u>	<u>\$ 37,335</u>

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Caseyville Nursing & Rehabilitation Center

0039644 Report Period Beginning:

01/01/2005 Ending:

12/31/2005

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 38,932 B. General Construction Type: Exterior Brick Frame Wood Number of Stories One

C. Does the Operating Entity? ☐ (a) Own the Facility ☒ (b) Rent from a Related Organization ☐ (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions)

D. Does the Operating Entity? ☒ (a) Own the Equipment ☒ (b) Rent equipment from a Related Organization ☒ (c) Rent equipment from Completely Unrelated Organization

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's ground (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable)

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? ☐ YES ☒ NO
If so, please complete the following:1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized
3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:

(Attach a complete schedule detailing the total amount of organization and pre-operating costs)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Resident Care		2001	\$ 350,000	1
2					2
3	TOTALS			\$ 350,000	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Caseyville Nursing & Rehabilitation Center

0039644

Report Period Beginning:

01/01/2005 Ending: 12/31/2005

XI. OWNERSHIP COSTS (continued)**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar**

1	2	3	4	5	6	7	8	9	
Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
4	150	2001	2001	\$ 5,265,178	\$		\$ 146,725	\$ 146,725	\$ 592,478
5									
6									
7	Management Allocation	1995		41,567		39	1,188	1,188	12,654
8									
Improvement Type**									
9	Various	1994		22,302	203	20	1,115	912	12,537
10	Various	1995		52,604	107	20	2,630	2,523	28,065
11	Various	1996		2,492		20	125	125	1,311
12	Various	1997		11,349	43	20	567	524	4,826
13	Various	1998		14,511	227	20	726	499	6,296
14	Various	1999		83,394	613	20	4,170	3,557	26,763
15	Parking Lot	2000		2,830	176	20	142	(34)	756
16	Sprinkler System	2000		3,385	87	20	169	82	959
17	Sprinkler System	2000		5,820	149	20	291	142	1,673
18	A/C Repairs	2000		1,018		10	102	102	570
19	Ac Repairs	2000		1,102		20	55	55	307
20	Draperies	2000		1,052		20	53	53	277
21	Carpeting	2000		1,578		20	80	80	448
22	Air Handler	2000		1,786		20	89	89	491
23	Air Conditioner	2000		1,963		7	280	280	903
24	Air Handler	2000		1,241		20	62	62	341
25	Air Conditioner	2000		1,029		20	51	51	290
26	Compressor	2000		1,800		20	90	90	540
27	Booster Heater	2000		1,675		20	84	84	504
28	Air Conditioner	2000		5,821		20	291	291	1,552
29	Air Conditioner	2000		17,320		20	866	866	4,835
30	Air Conditioner	2001		3,630		20	182	182	848
31	Air Conditioner	2001		3,630		20	182	182	848
32	Air Conditioner	2001		3,111		20	156	156	727
33	Blinds	2001		1,212		20	61	61	294
34	Sprinkler Repair	2001		1,609		20	80	80	388
35	Sprinkler Heads	2001		2,145		20	107	107	500
36	Pipes Repair	2001		1,903		20	95	95	388

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

SEE ACCOUNTANTS' COMPILATION REPORT

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

1	2	3	4	5	6	7	8	9	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	Dining Room Wall	2002	\$ 10,650	\$ 191	10	\$ 1,065	\$ 874	\$ 3,905	37
38	Water Heater	2002	4,900		12	408	408	1,599	38
39	Circuit Breaker	2002	1,390		10	139	139	533	39
40	Air Conditioners	2002	2,890		7	413	413	1,411	40
41	Air Conditioners	2002	4,284		7	612	612	2,142	41
42	Water Heater	2002	2,249		12	187	187	593	42
43	Doors	2003	9,995	256	20	500	244	1,500	43
44	Dry Value System	2003	5,623	144	20	281	137	726	44
45	Landscaping	2003	8,800	762	20	440	(322)	1,027	45
46	Nursing Stations	2003	35,000	1,273	20	1,750	477	3,646	46
47	Repair Fire Protection Equipment	2003	1,694		20	85	85	255	47
48	P.A. Amplifier	2003	713		20	36	36	108	48
49	Security Systems	2004	23,268	901	20	1,163	262	1,745	49
50	16 Transmitters	2004	1,517		20	76	76	114	50
51	Nurses Stations	2004	35,000		20	1,750	1,750	2,625	51
52	Wardrobe units w/ Installation	2004	46,731	1,699	20	2,337	638	3,505	52
53	Cabinets and Countertops	2005	85,938	2,995	20	2,148	(847)	2,148	53
54	Air Conditioners	2005	20,666	4,133	7	2,067	(2,066)	2,067	54
55	Freezer Door	2005	2,100	2,100	20	53	(2,047)	53	55
56	Wallpaper	2005	16,140	16,140	20	1,614	(14,526)	1,614	56
57	Sprinkler System	2005	5,545	109	20	139	30	139	57
58	Painting and Wallcovering	2005	38,520	38,520	20	3,852	(34,668)	3,852	58
59	Air Condensors	2005	6,270	105	20	157	52	157	59
60	Vinyl Flooring	2005	5,009	53	20	501	448	501	60
61	Paving and Sealing Sidewalks	2005	7,000	350	20	233	(117)	233	61
62	Metal Doors	2005	1,926	15	20	48	33	48	62
63									63
64	Allocation from SW management - leasehold improvement	1995	4,435		20	222	222	2,675	64
65	Allocation from SW management - leasehold improvement	1996	775		20	39	39	370	65
66	Allocation from SW management - leasehold improvement	1997	1,115		20	56	56	612	66
67	Allocation from SW management - leasehold improvement	1998	768		20	38	38	298	67
68	Allocation from SW management - leasehold improvement	1999	2,132		20	107	107	649	68
69	Allocation from SW management - leasehold improvement	2005	4,410		20	110	110	110	69
70	TOTAL (lines 4 thru 69)		\$ 5,957,510	\$ 71,351		\$ 183,440	\$ 112,089	\$ 744,329	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Caseyville Nursing & Rehabilitation Center

0039644

Report Period Beginning:

01/01/2005

Ending:

12/31/2005

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instruction

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component/ Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 1,032,612	\$ 11,309	\$ 182,339	\$ 171,030	10-20	\$ 783,435	71
72	Current Year Purchases	14,726	14,726	732	(13,994)	10	732	72
73	Fully Depreciated Assets							73
74	Allocation from Management Co.	11,220		1,098	1,098		10,241	74
75	TOTALS	\$ 1,058,558	\$ 26,035	\$ 184,169	\$ 158,134		\$ 794,408	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Allocation from Mgmt. Co.	2004 Cadillac	2004	\$ 5,566	\$	\$ 1,113	\$ 1,113	5	\$ 1,670	76
77										77
78										78
79										79
80	TOTALS			\$ 5,566	\$	\$ 1,113	\$ 1,113		\$ 1,670	80

E. Summary of Care-Related Asset

	1 Reference	2 Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 7,371,634	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 97,386	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 368,722	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 271,336	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,540,407	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		\$	\$	\$	86
87	N/A				87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progres

	Description	Cost	
92		\$	92
93	N/A		93
94			94
95		\$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column f

SEE ACCOUNTANTS' COMPILATION REPORT

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A
 2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
 If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$ <u>N/A</u>			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

8. List separately any amortization of lease expense included on page 4, line 34.
 This amount was calculated by dividing the total amount to be amortized
 by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO
 16. Rental Amount for movable equipment: \$ 280 Description: Copier; \$280

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	<u>Allocation from Mgmt. Co.</u>		\$	\$ <u>1,168</u>	17
18					18
19					19
20					20
21	TOTAL		\$	\$ <u>1,168</u>	21

10. Effective dates of current rental agreement:

Beginning
 Ending

11. Rent to be paid in future years under the current rental agreement:

Fiscal Year Ending Annual Rent

12. /2006 \$
 13. /2007 \$
 14. /2008 \$

* If there is an option to buy the building,
 please provide complete details on attached
 schedule.

** This amount plus any amortization of lease
 expense must agree with page 4, line 34.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Caseyville Nursing & Rehabilitation Center # 0039644 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO It is the policy of this facility to only hire certified nurses aides If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.	2. CLASSROOM PORTION: IN-HOUSE PROGRAM <input type="checkbox"/> IN OTHER FACILITY <input type="checkbox"/> COMMUNITY COLLEGE <input type="checkbox"/> HOURS PER CNA _____	3. CLINICAL PORTION: IN-HOUSE PROGRAM <input type="checkbox"/> IN OTHER FACILITY <input type="checkbox"/> HOURS PER CNA _____
---	--	---

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wage (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

(a) Include wages paid during the classroom portion of training. Do not include fringe benefit.

(b) Include wages paid during the clinical portion of training. Do not include fringe benefit.

(c) For in-house training programs only. Do not include fringe benefit.

(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.

(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

SEE ACCOUNTANTS' COMPILATION REPORT

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training CNAs from other facilities:

\$ _____

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	L10A, C3	hrs	\$	15,776	\$ 268,199	\$	15,776	\$ 268,199	1
2	Licensed Speech and Language Development Therapist	L10A, C3	hrs		2,612	67,922		2,612	67,922	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	L10A, C3	hrs		16,873	269,962		16,873	269,962	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	L39, C2	# of prescripts				96,513		96,513	9
	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							
10			hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): Ambulance	L39, C3					548		548	13
14	TOTAL			\$	35,261	\$ 606,083	\$ 97,061	35,261	\$ 703,144	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 136,195	\$ 287,516	1
2	Cash-Patient Deposits	10,910	10,910	2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	1,002,965	1,002,965	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	31,261	68,586	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>See Schedule 17A</u>	360,662	476,204	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,541,993	\$ 1,846,181	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		350,000	13
14	Buildings, at Historical Cost		5,265,179	14
15	Leasehold Improvements, at Historical Cost	386,059	692,331	15
16	Equipment, at Historical Cost	408,427	1,064,124	16
17	Accumulated Depreciation (book methods)	(488,192)	(1,540,407)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (sp. <u>See Sch. 17A</u>)		147,908	22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 306,294	\$ 5,979,135	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,848,287	\$ 7,825,316	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 145,126	\$ 149,626	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	21,132	21,132	28
29	Short-Term Notes Payable	721,963	721,963	29
30	Accrued Salaries Payable	128,311	128,311	30
31	Accrued Taxes Payable (excluding real estate taxes)	14,778	14,778	31
32	Accrued Real Estate Taxes(Sch.IX-B)		87,000	32
33	Accrued Interest Payable		108,748	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>See Schedule 17A</u>	294,372	102,349	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,325,682	\$ 1,333,907	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		6,583,462	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$ 6,583,462	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,325,682	\$ 7,917,369	46
47	TOTAL EQUITY (page 18, line 24)	\$ 522,605	\$ (92,053)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,848,287	\$ 7,825,316	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

Caseyville Nursing & Rehabilitation Center
 Provider #: 0039644
 12/31/05

Schedule 17A

XV. BALANCE SHEET -

Other Current Assets (specify):	After	
	Operating	Consolidation
Insurance Escrow		16,108
MIP Escrow		943
Replacement reserve		79,168
Real estate tax escrow		19,323
Employee payroll advance	166	166
Reimbursement due	1,392	1,392
Short term loan exchange	347,644	347,644
Due from public aid	11,460	11,460
Total Line 9 - Other Current Assets (specify):	360,662	476,204

Other Long-Term Assets (specify):	After	
	Operating	Consolidation
Mortgage Costs	0	167,434
Accumulated Amortization	0	(19,526)
Total Line 22 - Other Long-Term Assets (specify):	0	147,908

Other Current Liabilities (specify):	After	
	Operating	Consolidation
Insurance Premiums Payable	1,271	1,271
Accrued retirement	(300)	(300)
Accrued expenses	85,403	85,403
Due to Caseyville Properties	207,998	15,975
Total Line 36 - Other Current Liabilities (specify):	294,372	102,349

See Accountants' Compilation Report

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 245,988	1
2	Restatements (describe):		2
3	Prior Period Adjustments	6,070	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 252,058	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	270,547	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 270,547	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 522,605	24 *

Operating Entity Only

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Page 19

Facility Name & ID Number Caseyville Nursing & Rehabilitation Center

0039644

Report Period Beginning: 01/01/2005

Ending: 12/31/2005

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached

Note: This schedule should show gross revenue and expenses. Do not net revenue against expenses

1			
	Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 5,336,848	1
2	Discounts and Allowances for all Levels		2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 5,336,848	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	524,409	6
7	Oxygen	16,054	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 540,463	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursement		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patient		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income**	14,692	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 14,692	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Miscellaneous Income	797	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 797	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 5,892,800	30

2			
	Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,043,764	31
32	Health Care	2,374,612	32
33	General Administration	1,128,679	33
	B. Capital Expense		
34	Ownership	862,766	34
	C. Ancillary Expense		
35	Special Cost Centers	130,307	35
36	Provider Participation Fee	82,125	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 5,622,253	40
41	Income before Income Taxes (line 30 minus line 40)**	270,547	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 270,547	43

* This must agree with page 4, line 45, column 4.

** Does this agree with taxable income (loss) per Federal Income Tax Return? No If not, please attach a reconciliation.
This entity is a cash basis taxpayer.

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation. SEE ACCOUNTANTS' COMPILATION REPORT

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name & ID Number Caseville Nursing & Rehabilitation Center

0039644

Report Period Beginning: 01/01/2005

Ending:

12/31/2005

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,784	2,080	\$ 55,768	\$ 26.81	1
2	Assistant Director of Nursing	1,680	1,968	43,819	22.27	2
3	Registered Nurses	2,915	3,125	77,452	24.78	3
4	Licensed Practical Nurses	24,691	26,328	525,135	19.95	4
5	CNAs & Orderlies	82,463	87,628	848,268	9.68	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	6,074	6,684	65,788	9.84	8
9	Activity Director					9
10	Activity Assistants	5,324	5,722	63,123	11.03	10
11	Social Service Worker	3,177	3,450	43,946	12.74	11
12	Dietician					12
13	Food Service Supervisor	1,826	2,080	33,988	16.34	13
14	Head Cook	10,012	10,921	105,519	9.66	14
15	Cook Helpers/Assistants	8,458	8,988	67,102	7.47	15
16	Dishwashers					16
17	Maintenance Worker	6,107	6,549	97,326	14.86	17
18	Housekeepers	13,922	14,898	120,612	8.10	18
19	Laundry	12,987	13,922	103,759	7.45	19
20	Administrator	1,984	2,080	81,645	39.25	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	11,891	12,798	278,339	21.75	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	195,295	209,221	\$ 2,611,589 *	\$ 12.48	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	Monthly	\$ 9,652	L1, C3	35
36	Medical Director	Monthly	4,800	L9, C3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	4,200	L10, C3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant	Monthly	9,502	L10A, C3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 28,154		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses		\$		50
51	Licensed Practical Nurses		N/A		51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)		\$		53

SEE ACCOUNTANTS' COMPILATION REPORT

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description		Amount	Description	Amount
<u>Gerri Isenberg</u>	<u>Administrator</u>	<u>0</u>	<u>\$ 81,645</u>	<u>Workers' Compensation Insurance</u>		<u>\$ 58,972</u>	<u>IDPH License Fee</u>	<u>\$ 1,990</u>
				<u>Unemployment Compensation Insurance</u>		<u>48,880</u>	<u>Advertising: Employee Recruitment</u>	
				<u>FICA Taxes</u>		<u>199,787</u>	<u>Health Care Worker Background Check</u>	
				<u>Employee Health Insurance</u>		<u>55,665</u>	<u>(Indicate # of checks performed <u>122</u>)</u>	<u>1,462</u>
				<u>Employee Meals</u>		<u>3,801</u>	<u>Miscellaneous Licenses</u>	<u>722</u>
				<u>Illinois Municipal Retirement Fund (IMRF)*</u>			<u>Miscellaneous Dues & Subscriptions</u>	<u>122</u>
				<u>Employee Morale</u>		<u>2,729</u>		
							<u>Management Company Allocation</u>	<u>62</u>
							<u>Less: Public Relations Expense</u>	<u>()</u>
							<u>Non-allowable advertising</u>	<u>()</u>
							<u>Yellow page advertising</u>	<u>()</u>
TOTAL (agree to Schedule V, line 17, col. 1)							TOTAL (agree to Sch. V, line 20, col. 8)	\$ 4,358
(List each licensed administrator separately.)			\$ 81,645			\$ 369,834		
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Description			Amount	Description	Line #	Amount	Description	Amount
<u>SW Management fees</u>			<u>\$ 60,000</u>	<u>N/A</u>			<u>Out-of-State Travel</u>	<u>\$</u>
<u>SW Management - Home Office</u>			<u>123,250</u>					
<u>Ronnie Klein - Management fees</u>			<u>60,000</u>				<u>In-State Travel</u>	
							<u>Management Company Allocation</u>	<u>37</u>
TOTAL (agree to Schedule V, line 17, col. 3)			\$ 243,250				<u>Seminar Expense</u>	<u>648</u>
(Attach a copy of any management service agreement)								
C. Professional Services							<u>Entertainment Expense</u>	<u>()</u>
Vendor/Payee	Type		Amount				TOTAL (agree to Sch. V, line 24, col. 8)	\$ 685
<u>Burroughs, Hepler, Broom</u>	<u>Legal</u>		<u>\$ 35,495</u>					
<u>Ashman & Stein</u>	<u>Legal</u>		<u>7,831</u>					
<u>Winston & Strawn</u>	<u>Legal</u>		<u>400</u>					
<u>Fendelman, Paull & Associates</u>	<u>Legal</u>		<u>35</u>					
<u>American Express TBS</u>	<u>Accounting</u>		<u>14,893</u>					
<u>Personnel Planners</u>	<u>Unemployment Consultant</u>		<u>2,505</u>					
TOTAL (agree to Schedule V, line 19, column 3)				TOTAL		\$		
(If total legal fees exceed \$2500 attach copy of invoices.)			\$ 61,159					

* Attach copy of IMRF notifications
SEE ACCOUNTANTS' COMPILATION REPORT

**See instructions.

Caseyville Nursing & Rehabilitation Center

Provider #: 0039644

01/01/2005 to 12/31/2005

Schedule 21A

XIX. SUPPORT SCHEDULE

C. Professional Services

Total (agree to Schedule V, line 19, column 3)	61,159
Allocated from Caseyville Properties, LLC	
Accounting - Reznick Group	5,000
Allocated from Management Company	
Legal	1,448
Accounting - Frost, Ruttenberg & Rothblatt/American Express TBS	1,353
Professional Services Disallowed	(795)
Total (agree to Schedule V, line 19, column 8)	<u>68,165</u>

SEE ACCOUNTANTS' COMPILATION REPORT

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
 (See instructions.)

	1 Improvement Type	2 Month & Year Improvement Was Made	3 Total Cost	4 Useful Life	5 Amount of Expense Amortized Per Year								
					6 FY2002	7 FY2003	8 FY2004	9 FY2005	10 FY2006	11 FY2007	12 FY2008	13 FY2009	14 FY2010
1			\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3		N/A											
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Caseyville Nursing & Rehabilitation Center

0039644

Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union No
- (2) Are there any dues to nursing home associations included on the cost report No
If YES, give association name and amount N/A
- (3) Did the nursing home make political contributions or payments to a political organization? No If YES, have these costs been properly adjusted out of the cost report? N/A
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases Yes
What was the average life used for new equipment added during this period 10 Years
- (6) Indicate the total amount of both disposable and non-disposable diaper expenses and the location of this expense on Sch. V. 95 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease N/A
- (9) Are you presently operating under a sublease agreement YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility IDPH license number of this related party and the date the present owners took over N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 82,125
This amount is to be recorded on line 42 of Schedule V
- (12) Are there any salary costs which have been allocated to more than one line on Schedule for an individual employee? No If YES, attach an explanation of the allocation

SEE ACCOUNTANTS' COMPILATION REPORT

- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services if the patient census listed on page 2, Section B No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these function
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 3,801 Has any meal income been offset against related costs? N/A Indicate the amount \$ N/A
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel No
If YES, attach a complete explanation
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such program during this reporting period. \$ N/A
c. What percent of all travel expense relates to transportation of nurses and patients? N/A
d. Have vehicle usage logs been maintained Adequate records have been maintained
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? Yes
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: N/A The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? N/A If no, please explain. N/A
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? Yes
Attach invoices and a summary of services for all architect and appraisal fees

RECONCILIATION REPORT

10:26 AM 5/16/2006

ITEM	Value 1	Cond.	Value 2	Difference	RESULTS	COMPARE CEL	SUB- SCHED.	LINE NO.	COL. NO.	WITH CELL	SUB- SCHED.	LINE NO.	COL. NO.
Adjustment Detail	-15,942	equal to	-15,942	0	O.K.	Pg5 Z22	B.	37	1	Pg4 K29	N/A	45	7
Interest Expense	410,665	equal to	410,665	0	O.K.	Pg9 P34	A.	15	10	Pg4 L13	N/A	32	8
Real Estate Tax Expenses	95,330	equal to	95,330	0	O.K.	Pg10 W24	B.	5	N/A	Pg4 L14	N/A	33	8
Amortization exp. Pre-opening & org.	0	equal to	0	0	O.K.	Pg11 I33	E.	3	N/A	Pg4 L12	N/A	31	8
Ownership Costs-Depreciation	368,722	equal to	368,722	0	O.K.	Pg13 Y28	E.	49	2	Pg4 L11	N/A	30	8
Rental Costs A	0	equal to	0	0	O.K.	Pg14 L20+N22	A.	7 + 8	4+N/A	Pg4 L15	N/A	34	8
Rental Costs B	1,448	equal to	1,448	0	O.K.	Pg14 J30+N40	B.+ C.	16+21	N/A+4	Pg4 L16	N/A	35	8
Nurse Aid Training Prog.	0	equal to	0	0	O.K.	Pg15 L36	B.	10	1	Pg3 L23	N/A	13	8
Special Serv.- Staff Wages	0	equal to	0	0	O.K.	Pg16 N32	N/A	14	3	Pg4 E22	N/A	39	1
Therapy Services	615,585	equal to	615,585	0	O.K.	Pg16 Z12+Z14.	N/A/B	1-4;40-43	8;2	Pg3 H20	N/A	10a	4
Special Serv.- Supplies	97,061	equal to	97,061	0	O.K.	Pg16 V32	N/A	14	6	Pg4 F22 + Pg 3	N/A	39,10a	2
Income Stat. General Serv.	1,043,764	equal to	1,043,764	0	O.K.	Pg19 P11	N/A	31	2	Pg3 H16	N/A	8	4
Income Stat. Health Care	2,374,612	equal to	2,374,612	0	O.K.	Pg19 P12	N/A	32	2	Pg3 H26	N/A	16	4
Income Stat. Administration	1,128,679	equal to	1,128,679	0	O.K.	Pg19 P13	N/A	33	2	Pg3 H39	N/A	28	4
Income Stat. Ownership	862,766	equal to	862,766	0	O.K.	Pg19 P15	N/A	34	2	Pg4 H18	N/A	37	4
Income Stat. Special Cost Ctr	130,307	equal to	130,307	0	O.K.	Pg19 P17	N/A	35	2	Pg4 H21..H24+i	N/A	38to41+43	4
Income Stat. Prov. Partic.	82,125	equal to	82,125	0	O.K.	Pg19 P18	N/A	36	2	Pg4 H25	N/A	42	4
Staff- Nursing	1,550,442	equal to	1,616,230	-65,788	FAILED	Pg20 K11..K15+	A.	1-5,24,25,27-30	3	Pg3 E19	N/A	10	1
Staff- Nurse aide Training	0	< or = to	0	0	O.K.	Pg20 K16	A.	6	3	Pg3 E23	N/A	13	1
Staff-Licensed Therapist	0	equal to	0	0	O.K.	Pg20 K17	A.	7	3	Pg4 E22	N/A	39	1
Staff- Activities	63,123	equal to	63,123	0	O.K.	Pg20 K19+K20	A.	9+10	3	Pg3 E21	N/A	11	1
Staff- Social Serv. Workers	43,946	equal to	43,946	0	O.K.	Pg20 K21	A.	11	3	Pg3 E22	N/A	12	1
Staff- Dietary	206,609	equal to	206,609	0	O.K.	Pg20 K22..K26	A.	16-Dec	3	Pg3 E9	N/A	1	1
Staff- Maintenance	97,326	equal to	97,326	0	O.K.	Pg20 K27	A.	17	3	Pg3 E14	N/A	6	1
Staff- Housekeeping	120,612	equal to	120,612	0	O.K.	Pg20 K28	A.	18	3	Pg3 E11	N/A	3	1
Staff- Laundry	103,759	equal to	103,759	0	O.K.	Pg20 K29	A.	19	3	Pg3 E12	N/A	4	1
Staff- Administrative	81,645	equal to	81,645	0	O.K.	Pg20 K30..K32	A.	20-22	3	Pg3 E28	N/A	17	1
Staff- Clerical	278,339	equal to	278,339	0	O.K.	Pg20 K33..K34	A.	23+24	3	Pg3 E32	N/A	21	1
Staff- Medical Director	0	equal to	0	0	O.K.	Pg20 K37	A.	27	3	Pg3 E18	N/A	9	1
Total Salaries And Wages	2,611,589	equal to	2,611,589	0	O.K.	Pg20 K44	A.	34	3	Pg4 E29	N/A	45	1
Dietary Consultant	9,652	< or = to	9,652	0	O.K.	Pg20 X12	B.	35	2	Pg3 G9	N/A	1	3
Medical Director	4,800	< or = to	4,800	0	O.K.	Pg20 X13	B.	36	2	Pg3 G18	N/A	9	3
Consultants & contractors	4,200	< or = to	4,200	0	O.K.	Pg20 X14..X16+	B. & C.	17to39 and 50to6	2	Pg3 G19	N/A	10	3
Activity Consultant	0	< or = to	0	0	O.K.	Pg20 X21	B.	44	2	Pg3 G21	N/A	11	3
Social Service Consultant	0	< or = to	0	0	O.K.	Pg20 X22	B.	45	2	Pg3 G22	N/A	12	3
Supp. Sched.- Admin. Salar.	81,645	equal to	81,645	0	O.K.	Pg21 I16	A.	N/A	N/A	Pg3 E28	N/A	17	1
Supp. Sched.- Admin. Other	243,250	equal to	243,250	0	O.K.	Pg21 I24	B.	N/A	N/A	Pg3 G28	N/A	17	3
Supp. Sched.- Prof. Serv.	61,159	equal to	61,159	0	O.K.	Pg21 I41	C.	N/A	N/A	Pg3 G30	N/A	19	3
Supp. Sched.- Benefit/Taxes	369,834	equal to	369,834	0	O.K.	Pg21 P22	D.	N/A	N/A	Pg3 L33	N/A	22	8
Supp. Sched.- Sched of dues..	4,358	equal to	4,358	0	O.K.	Pg21 V22	F.	N/A	N/A	Pg3 L31	N/A	20	8
Supp. Sched.- Sched. of trav	685	equal to	685	0	O.K.	Pg21 V41	G.	N/A	N/A	Pg3 L35	N/A	24	8
Gen. Info - Particip. Fees	82,125	equal to	82,125	0	O.K.	Pg23 I38	N/A	11	N/A	Pg4 G25	N/A	42	3
Gen. Info - Employee Meals	3,801	< or = to	3,968	-167	O.K.	Pg23 S16	N/A	16	N/A	Pg3 K33	N/A	2 & 22	7
Gen. Info - Employee Meals	3,801	equal to	3,801	0	O.K.	Pg23 S16	N/A	16	N/A	Pg21 P12	D.	N/A	N/A
Nurse aide training	0	equal to	0	0	O.K.	Pg15 U29..U31	B.	3, 4 & 5	4	Pg3 E23	N/A	13	1
Days of medicare provided	3,330	equal to	3,330	0	O.K.	Pg2 AB29	K.	N/A	N/A	Pg2 J30	B.	8	4
Adjustment for related org. costs	108,880	equal to	108,880	0	O.K.	Pg5 Z18	B.	34	1	Pg6 to Pg 6l Y4	B.	14	8
Total loan balance	7,305,425	equal to	7,305,425	0	O.K.	Pg9 L34	A.	15	7	Pg17 V13+V27.	N/A	29+39-41	2
Real estate tax accrual	87,000	equal to	87,000	0	O.K.	Pg10 W15	B.	4	N/A	Pg17 V17	N/A	32	2
Land	350,000	equal to	350,000	0	O.K.	Pg11 T43	A.	3	4	Pg17 K25	N/A	13	2
Building cost	5,957,510	equal to	5,957,510	0	O.K.	Pg12 to 12l L43	B.	36	4	Pg17 K26+K27	N/A	14 & 15	2
Equipment and vehicle cost	1,064,124	equal to	1,064,124	0	O.K.	Pg13 O22+L13	C. & D.	41 + 46	1 + 4	Pg17 K28	N/A	16	2
Accumulated depr.	1,540,407	equal to	1,540,407	0	O.K.	Pg13 Y30	E.	51	2	Pg17 K29	N/A	17	2
End of year equity	522,605	equal to	522,605	0	O.K.	Pg18 I33	N/A	24	1	Pg17 S39	N/A	47	1
Net income (loss)	270,547	equal to	270,547	0	O.K.	Pg18 I15	N/A	7	1	Pg19 P30	N/A	43	2
Unamortized deferred maint. cost	0	equal to	0	0	O.K.	Pg22 F31-J31..1	H.	20	3	Pg17 K30	N/A	18	2
Balance Sheet	1,848,287	equal to	1,848,287	0	O.K.	Pg17 H41		25	1	Pg17 S41	N/A	48	1

Caseville Nursing & Rehabilitation Center
IDPA Comparative Data - Per Resident Day Cost
Year Ending 12/31/2005

Enter your HSA # in next column
Census (Pulls from Page 2)

1

47,659

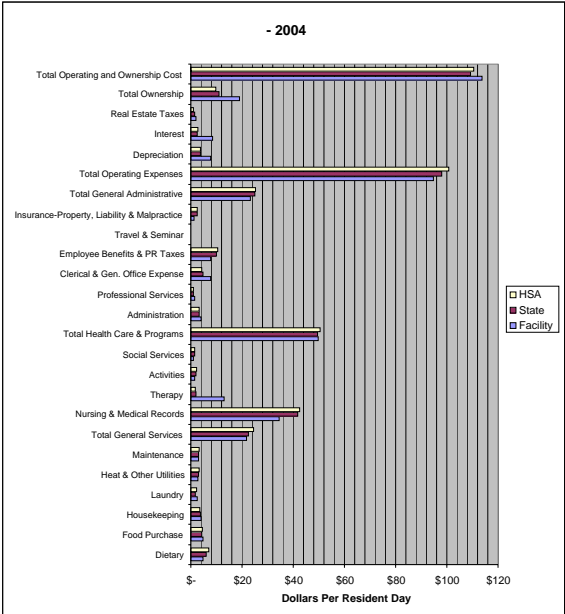
Cost Report Line	Description	Your Facility		Average Median Cost Per Day		State	HSA	IDPA LTC Profiles												10th %	90th %															
		State	HSA	LTC Median Per Diem Cost by HSA - 2003 Cost Reports 2003 (Run June 1, 2004)					UN-INFLATED																											
1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37
1	Dietary	4.85	6.01	7.02	1	Dietary	6.01	7.02	6.48	5.50	6.48	5.48	6.06	6.06	6.06	5.60	7.02	5.70	4.13	9.81																
2	Food Purchase	4.63	4.31	4.47	2	Food Purchase	4.31	4.47	4.40	4.27	4.40	3.99	4.31	4.31	4.31	4.28	4.47	4.11	3.36	6.04																
3	Housekeeping	4.08	3.70	3.59	3	Housekeeping	3.70	3.59	3.68	2.91	3.68	3.40	4.05	4.05	4.05	3.97	3.59	3.61	2.48	5.80																
4	Laundry	2.47	1.85	2.23	4	Laundry	1.85	2.23	1.90	1.79	1.90	2.10	1.59	1.59	1.59	1.69	2.23	2.13	0.91	3.14																
5	Heat & Other Utilities	2.81	2.95	3.17	5	Heat & Other Utilities	2.95	3.17	2.93	2.94	2.93	2.71	2.93	2.93	2.93	2.91	3.17	2.95	2.05	4.25																
6	Maintenance	3.00	3.01	3.26	6	Maintenance	3.01	3.26	3.03	2.99	3.03	2.55	3.21	3.21	3.21	3.05	3.26	2.82	1.92	5.12																
8	Total General Services	21.84	22.58	24.49	8	TOTAL GENERAL SERVICES	22.58	24.49	22.99	21.47	22.99	21.47	22.65	22.65	22.65	22.45	24.49	21.73	17.57	31.51																
10	Nursing & Medical Records	34.44	41.83	42.52	10	Nursing & Medical Records	41.83	42.52	43.12	38.37	43.12	33.78	45.12	45.12	45.12	47.22	42.52	42.15	27.25	64.47																
10A	Therapy	12.92	2.10	1.86	10A	Therapy	2.10	1.86	2.69	3.34	2.69	3.47	1.45	1.45	1.45	2.41	1.86	2.24	-	10.55																
11	Activities	1.44	1.91	2.18	11	Activities	1.91	2.18	1.92	1.61	1.92	1.48	2.16	2.16	2.16	2.05	2.18	1.54	1.06	3.45																
12	Social Services	0.92	1.42	1.45	12	Social Services	1.45	1.42	1.64	1.05	1.64	1.09	1.60	1.60	1.60	1.12	1.45	1.27	0.58	3.00																
16	Total Health Care & Programs	49.82	49.48	50.39	16	TOTAL HEALTH CARE & PROGRAMS	49.48	50.39	51.22	46.39	51.22	41.58	52.34	52.34	52.34	54.96	50.39	49.49	32.10	77.23																
17	Administration	4.03	3.36	3.33	17	Administration	3.33	3.15	3.15	3.15	3.60	3.46	3.46	3.46	3.46	3.04	3.33	3.17	1.71	7.21																
19	Professional Services	1.43	0.99	1.09	19	Professional Services	0.99	1.09	0.85	0.83	0.85	0.76	1.12	1.12	1.12	1.13	1.09	0.77	0.07	3.44																
21	Clerical & Gen. Office Expense	7.77	4.79	4.32	21	Clerical & Gen. Office Expense	4.32	4.79	3.98	4.97	3.46	5.56	5.56	5.56	5.56	5.04	4.32	4.25	2.49	10.78																
22	Employee Benefits & PR Taxes	7.76	10.09	10.42	22	Employee Benefits & PR Taxes	10.09	10.42	11.01	8.88	11.01	7.67	10.51	10.51	10.51	11.38	10.42	9.08	6.33	19.34																
24	Travel & Seminar	0.01	0.08	0.10	24	Travel & Seminar	0.08	0.10	0.13	0.10	0.13	0.13	0.06	0.06	0.06	0.05	0.10	0.07	-	0.43																
26	Insurance-Property, Liability & Malpractice	1.16	2.58	2.47	26	Insurance-Property, liability & Malpractice	2.47	2.55	2.35	2.55	2.22	2.85	2.85	2.85	2.85	2.19	2.47	2.61	0.88	4.32																
28	Total General Administrative	23.15	24.94	25.31	28	TOTAL GENERAL ADMINISTRATIVE	24.94	25.31	26.11	23.02	26.11	21.37	25.81	25.81	25.81	26.59	25.31	22.93	16.95	39.14																
29	Total Operating Expenses	94.81	98.06	100.77	29	TOTAL OPERATING EXPENSES	98.06	100.77	100.03	92.47	100.03	88.05	100.96	100.96	100.96	103.01	100.77	94.71	69.40	142.56																
30	Depreciation	7.74	3.70	3.82	30	Depreciation	3.70	3.82	4.08	3.29	4.08	2.54	4.11	4.11	4.11	3.54	3.82	3.38	1.01	8.43																
32	Interest	8.62	2.54	2.81	32	Interest	2.54	2.81	1.96	2.09	1.96	1.41	4.05	4.05	4.05	2.63	2.81	1.50	-	11.53																
33	Real Estate Taxes	2.00	1.38	0.92	33	Real Estate Taxes	1.38	0.92	1.08	0.82	1.08	0.80	3.20	3.20	3.20	1.36	0.92	1.11	-	4.85																
37	Total Ownership	19.05	11.11	9.73	37	TOTAL OWNERSHIP	11.11	9.73	9.80	8.00	9.80	7.04	14.54	14.54	14.54	11.02	9.73	8.39	3.76	23.58																
Total Operating and Ownership Cost		113.86	111.11	110.50	TOTAL OPERATING & OWNERSHIP CC		109.17	110.50	109.83	100.47	109.83	95.09	115.50	115.50	115.50	114.03	110.50	103.10	73.16	166.14																

Notes:

Your Facility data is from page 3, column 8 of your 2005 Medicaid cost report, divided by your annual census.

The Average Median Cost Per Day for the State and your HSA is taken from data available from the Illinois Department of Public Aid and corresponds with the respective cost report data after final adjustments.

Notes:
Your Facility data is from page 3, column 8 of your 2005 Medicaid cost report, divided by your annual census.
The Average Median Cost Per Day for the State and your HSA is taken from data available from the Illinois Department of Public Aid and corresponds with the respective cost report data after final adjustments.

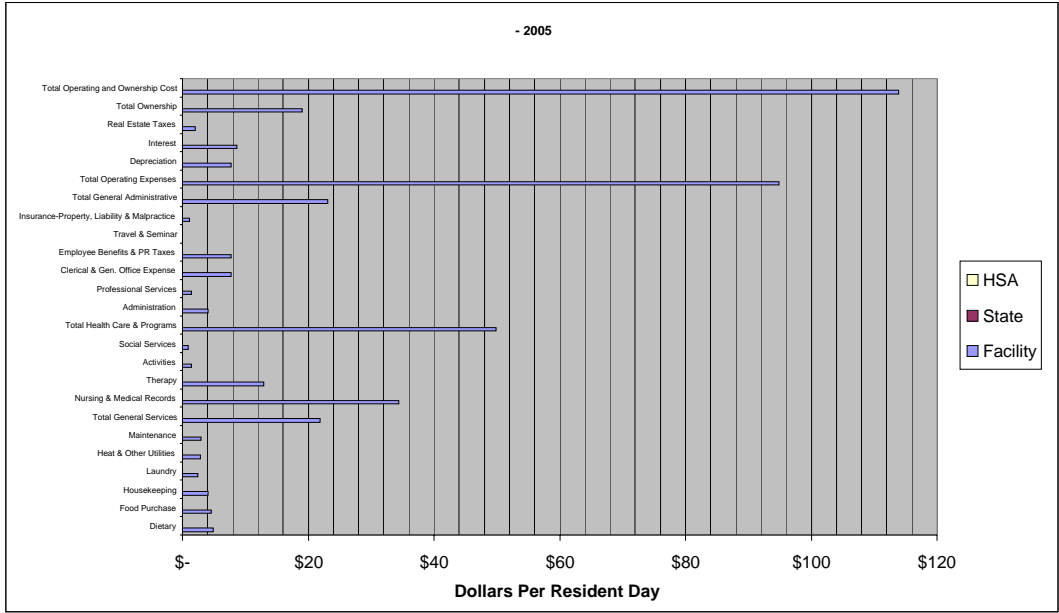


Cost Report Line	Description	2005	2004 Median		2004	2004 Median		2003	2003 Median		2002	2002 Median	
		Per Diem Your Facility	State	HSA	Per Diem Your Facility	State	HSA	Per Diem Your Facility	State	HSA	Per Diem Your Facility	State	HSA
1	Dietary	4.85	-	-	#DIV/0!	-	-	#DIV/0!	6.10	5.70	#DIV/0!	6.01	5.60
2	Food Purchase	4.63	-	-	#DIV/0!	-	-	#DIV/0!	4.31	4.11	#DIV/0!	4.27	4.09
3	Housekeeping	4.08	-	-	#DIV/0!	-	-	#DIV/0!	3.70	3.61	#DIV/0!	3.65	3.48
4	Laundry	2.47	-	-	#DIV/0!	-	-	#DIV/0!	1.85	2.13	#DIV/0!	1.90	2.23
5	Heat & Other Utilities	2.81	-	-	#DIV/0!	-	-	#DIV/0!	2.95	2.95	#DIV/0!	2.71	2.73
6	Maintenance	3.00	-	-	#DIV/0!	-	-	#DIV/0!	3.01	2.82	#DIV/0!	2.99	2.92
8	Total General Services	21.84	-	-	#DIV/0!	-	-	#DIV/0!	22.58	21.73	#DIV/0!	22.09	22.04
10	Nursing & Medical Records	34.44	-	-	#DIV/0!	-	-	#DIV/0!	41.83	42.15	#DIV/0!	40.68	41.16
10A	Therapy	12.92	-	-	#DIV/0!	-	-	#DIV/0!	2.10	2.24	#DIV/0!	1.85	2.27
11	Activities	1.44	-	-	#DIV/0!	-	-	#DIV/0!	1.91	1.54	#DIV/0!	1.88	1.60
12	Social Services	0.92	-	-	#DIV/0!	-	-	#DIV/0!	1.42	1.27	#DIV/0!	1.44	1.32
16	Total Health Care & Programs	49.82	-	-	#DIV/0!	-	-	#DIV/0!	49.48	49.49	#DIV/0!	47.55	47.76
17	Administration	4.03	-	-	#DIV/0!	-	-	#DIV/0!	3.36	3.17	#DIV/0!	3.39	3.54
19	Professional Services	1.43	-	-	#DIV/0!	-	-	#DIV/0!	0.99	0.77	#DIV/0!	0.98	0.72
21	Clerical & Gen. Office Expense	7.77	-	-	#DIV/0!	-	-	#DIV/0!	4.79	4.25	#DIV/0!	4.58	4.31
22	Employee Benefits & PR Taxes	7.76	-	-	#DIV/0!	-	-	#DIV/0!	10.09	9.08	#DIV/0!	9.63	8.44
24	Travel & Seminar	0.01	-	-	#DIV/0!	-	-	#DIV/0!	0.08	0.07	#DIV/0!	0.09	0.09
26	Insurance-Property, Liability & Malpractice	1.16	-	-	#DIV/0!	-	-	#DIV/0!	2.58	2.61	#DIV/0!	2.19	2.03
28	Total General Administrative	23.15	-	-	#DIV/0!	-	-	#DIV/0!	24.94	22.93	#DIV/0!	23.47	21.93
29	Total Operating Expenses	94.81	-	-	#DIV/0!	-	-	#DIV/0!	98.06	94.71	#DIV/0!	94.39	91.33
30	Depreciation	7.74	-	-	#DIV/0!	-	-	#DIV/0!	3.70	3.38	#DIV/0!	3.53	3.04
32	Interest	8.62	-	-	#DIV/0!	-	-	#DIV/0!	2.54	1.50	#DIV/0!	2.73	1.54
33	Real Estate Taxes	2.00	-	-	#DIV/0!	-	-	#DIV/0!	1.38	1.11	#DIV/0!	1.30	1.03
37	Total Ownership	19.05	-	-	#DIV/0!	-	-	#DIV/0!	11.11	8.39	#DIV/0!	11.44	10.00
	Total Operating and Ownership Cost	113.86	-	-	#DIV/0!	-	-	#DIV/0!	103.10	103.10	#DIV/0!	105.83	101.30

Notes:

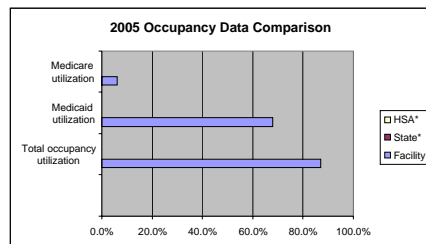
Your Facility data is from page 3, column 8 of each of your respective Medicaid cost reports, divided by the respective annual census.

The 2005, 2004, 2003 & 2002 Median Cost Per Day for the State and your HSA is taken from data available from the Illinois Department of Public Aid and corresponds with the respective cost report data after final adjustments.



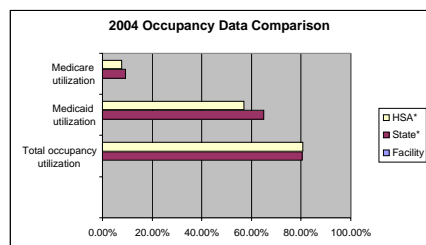
2005

Your Facility	State*	HSA*
Total occupancy utilization	87.05%	0.00%
Medicaid utilization	67.86%	0.00%
Medicare utilization	6.08%	0.00%
Private pay percent utilization	13.11%	N/A
Capacity in Patient Days	54,750	N/A
Census days of service provided	47,659	N/A



2004

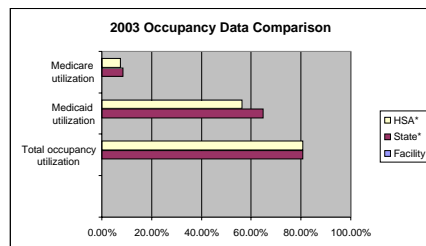
Your Facility	State*	HSA*
Total occupancy utilization	#DIV/0!	80.50%
Medicaid utilization	#DIV/0!	65.00%
Medicare utilization	#DIV/0!	9.40%
Private pay percent utilization	#DIV/0!	N/A
Capacity in Patient Days	N/A	N/A
Census days of service provided	N/A	N/A



* State and HSA data for 2004 and 2005 is not expected to be available from HFS until March 2006 and 2007 respectively.

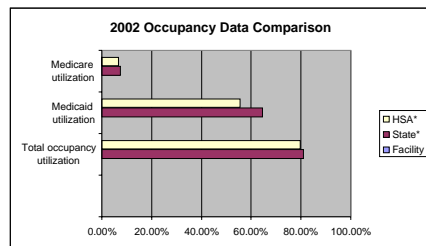
2003

Your Facility	State*	HSA*
Total occupancy utilization	#DIV/0!	80.80%
Medicaid utilization	#DIV/0!	64.80%
Medicare utilization	#DIV/0!	8.50%
Private pay percent utilization	#DIV/0!	N/A
Capacity in Patient Days	N/A	N/A
Census days of service provided	N/A	N/A

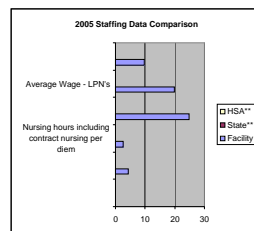


2002

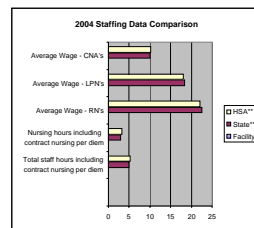
Your Facility	State*	HSA*
Total occupancy utilization	#DIV/0!	80.90%
Medicaid utilization	#DIV/0!	64.50%
Medicare utilization	#DIV/0!	7.40%
Private pay percent utilization	#DIV/0!	N/A
Capacity in Patient Days	N/A	N/A
Census days of service provided	N/A	N/A



2005			
Your			
Facility	State**	HSA**	
Total staff hours including contract nursing per diem	4.39	0.00	0.00
Nursing hours including contract nursing per diem	2.54	0.00	0.00
Average Wage - RN's	24.78	0.00	0.00
Average Wage - LPN's	19.95	0.00	0.00
Average Wage - CNA's	9.68	0.00	0.00

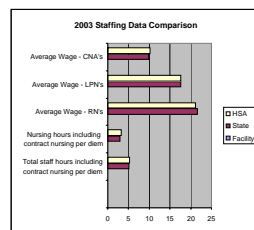


2004			
Your			
Facility	State**	HSA**	
Total staff hours including contract nursing per diem	5.00	5.30	
Nursing hours including contract nursing per diem	3.00	3.20	
Average Wage - RN's	22.54	22.05	
Average Wage - LPN's	18.40	18.02	
Average Wage - CNA's	10.02	10.13	

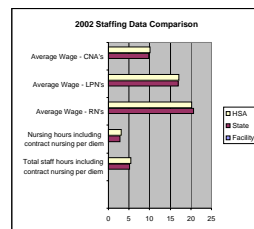


** State and HSA data for 2004 and 2005 is not expected to be available from HFS until March 2006 and 2007 respectively.

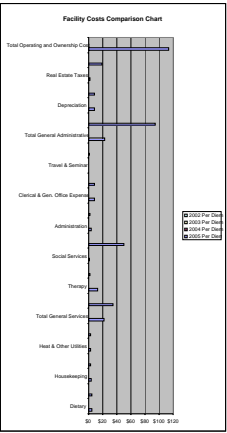
2003			
Your			
Facility	State	HSA	
Total staff hours including contract nursing per diem	5.10	5.30	
Nursing hours including contract nursing per diem	2.90	3.20	
Average Wage - RN's	21.56	21.14	
Average Wage - LPN's	17.64	17.65	
Average Wage - CNA's	9.91	10.11	



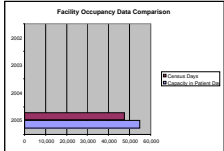
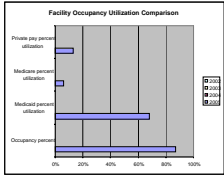
2002			
Your			
Facility	State	HSA	
Total staff hours including contract nursing per diem	5.20	5.50	
Nursing hours including contract nursing per diem	2.80	3.10	
Average Wage - RN's	20.69	20.12	
Average Wage - LPN's	16.89	17.04	
Average Wage - CNA's	9.73	10.05	



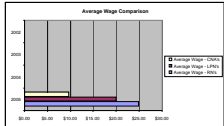
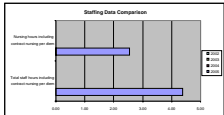
Cost Report Line	Account	Year 2003	Year 2004	Year 2005	Year 2006
		Facility	Facility	Facility	Facility
		2003	2004	2005	2006
		Per Bed	Per Bed	Per Bed	Per Bed
1	Stony	4.85	4500/01	4500/01	4500/01
2	Food Purchase	4.63	4500/01	4500/01	4500/01
3	Housekeeping	4.08	4500/01	4500/01	4500/01
4	Laundry	1.07	4500/01	4500/01	4500/01
5	Heat & Other Utilities	2.81	4500/01	4500/01	4500/01
6	Maintenance	3.05	4500/01	4500/01	4500/01
8	Total General Services	16.54	4500/01	4500/01	4500/01
10	Nursing & Medical Records	16.44	4500/01	4500/01	4500/01
10A	Therapy	12.92	4500/01	4500/01	4500/01
11	Activities	1.84	4500/01	4500/01	4500/01
12	Social Services	0.62	4500/01	4500/01	4500/01
16	Total Health Care & Programs	49.82	4500/01	4500/01	4500/01
17	Administration	6.07	4500/01	4500/01	4500/01
19	Professional Services	1.47	4500/01	4500/01	4500/01
21	Child & Gen. Office Expense	7.77	4500/01	4500/01	4500/01
22	Telephone, Bells & PK Taxes	1.76	4500/01	4500/01	4500/01
24	Travel & Lodging	0.91	4500/01	4500/01	4500/01
26	Insurance-Property, Liability & Malpractice	1.16	4500/01	4500/01	4500/01
28	Total General Administration	21.87	4500/01	4500/01	4500/01
29	Total Operating Expenses	96.91	4500/01	4500/01	4500/01
30	Depreciation	7.74	4500/01	4500/01	4500/01
32	Interest	8.42	4500/01	4500/01	4500/01
33	Real Estate Taxes	2.80	4500/01	4500/01	4500/01
37	Total Ownership	19.06	4500/01	4500/01	4500/01
Total Operating and Ownership Cost		115.96	4500/01	4500/01	4500/01



	Facility 2003	Facility 2004	Facility 2005	Facility 2006
Occupancy percent	87.00%	4500/01	4500/01	4500/01
Medicaid percent utilization	47.80%	4500/01	4500/01	4500/01
Medicare percent utilization	6.00%	4500/01	4500/01	4500/01
Private pay percent utilization	51.17%	4500/01	4500/01	4500/01
Capacity in Patient Days	58,750	0	0	0
Census Days	47,300	0	0	0



	Facility 2003	Facility 2004	Facility 2005	Facility 2006
Total staff hours including contract nursing per day	4.36	0.00	0.00	0.00
Nursing hours including contract nursing per day	2.50	0.00	0.00	0.00
Average Wage - BSN	24.78	0.00	0.00	0.00
Average Wage - LPN	19.80	0.00	0.00	0.00
Average Wage - CNA	9.80	0.00	0.00	0.00



	Salaries	Supplies	Other	Total	Reclass- ifications	Reclassified Total	Adjusted Adjustments	Adjusted Total
1. Dietary	206,609	14,835	9,652	231,096	0	231,096	0	231,096
2. Food Purchase	0	226,449	0	226,449	0	226,449	-5,827	220,622
3. Housekeeping	120,612	73,703	0	194,315	0	194,315	280	194,595
4. Laundry	103,759	14,025	0	117,784	0	117,784	0	117,784
5. Heat and Other Utilities	0	0	131,943	131,943	0	131,943	1,993	133,936
6. Maintenance	97,326	38,591	6,260	142,177	0	142,177	621	142,798
7. Other (specify)*	0	0	0	0	0	0	0	0
8. Total General Services	528,306	367,603	147,855	1,043,764	0	1,043,764	-2,933	1,040,831
9. Medical Director	0	0	4,800	4,800	0	4,800	0	4,800
10. Nursing & Medical Records	1,616,230	20,872	4,200	1,641,302	0	1,641,302	-43	1,641,259
10a. Therapy	0	0	615,585	615,585	0	615,585	0	615,585
11. Activities	63,123	5,650	0	68,773	0	68,773	0	68,773
12. Social Services	43,946	0	0	43,946	0	43,946	0	43,946
13. Nurse Aide Training	0	0	0	0	0	0	0	0
14. Program Transportation	0	0	206	206	0	206	0	206
15. Other (specify)*	0	0	0	0	0	0	0	0
16. Total Health Care & Programs	1,723,299	26,522	624,791	2,374,612	0	2,374,612	-43	2,374,569
17. Administrative	81,645	0	243,250	324,895	0	324,895	-132,929	191,966
18. Directors Fees	0	0	0	0	0	0	0	0
19. Professional Services	0	0	61,159	61,159	0	61,159	7,006	68,165
20. Fees, Subscriptions & Promotion	0	0	4,296	4,296	0	4,296	62	4,358
21. Clerical & General Office	278,339	0	24,289	302,628	0	302,628	67,728	370,356
22. Employee Benefits & Payroll	0	0	365,866	365,866	0	365,866	3,968	369,834
23. Inservice Training & Education	0	0	0	0	0	0	0	0
24. Travel and Seminar	0	0	2,733	2,733	0	2,733	-2,048	685
25. Other Admin. Staff Trans	0	0	27,547	27,547	0	27,547	324	27,871
26. Insurance-Prop.Liab.Malpractice	0	0	39,555	39,555	0	39,555	15,563	55,118
27. Other (specify)*	0	0	0	0	0	0	14,920	14,920
28. Total General Adminis	359,984	0	768,695	1,128,679	0	1,128,679	-25,406	1,103,273
29. Total General Administrative	2,611,589	394,125	1,541,341	4,547,055	0	4,547,055	-28,382	4,518,673
30. Depreciation	0	0	97,386	97,386	0	97,386	271,336	368,722
31. Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0
32. Interest	0	0	45,100	45,100	0	45,100	365,565	410,665
33. Real Estate	0	0	0	0	0	0	95,330	95,330
34. Rent - Facility & Grounds	0	0	720,000	720,000	0	720,000	-720,000	0
35. Rent - Equipment & Vehicles	0	0	280	280	0	280	1,168	1,448
36. Other (specify):*	0	0	0	0	0	0	31,739	31,739
37. Total Ownership	0	0	862,766	862,766	0	862,766	45,138	907,904
38. Medically Necessary T	0	0	0	0	0	0	0	0
39. Ancillary Service Cent	0	97,061	548	97,609	0	97,609	0	97,609
40. Barber and Beauty Shop	0	0	0	0	0	0	0	0
41. Coffee and Gift Shops	0	0	0	0	0	0	0	0
42	0	0	82,125	82,125	0	82,125	0	82,125
43. Other (specify):*	0	0	32,698	32,698	0	32,698	-32,698	0
44. Total Special Cost Ce	0	97,061	115,371	212,432	0	212,432	-32,698	179,734
45. Grand Total	2,611,589	491,186	2,519,478	5,622,253	0	5,622,253	-15,942	5,606,311

	Operating	After Consolidation
General Service Cost Center		
1. Cash on hand and in banks	136,195	287,516
2. Cash - Patient Deposits	10,910	10,910
3. Accounts & Notes Recievable	1,002,965	1,002,965
4. Supply Inventory	0	0
5. Short-Term Investments	0	0
6. Prepaid Insurance	31,261	68,586
7. Other Prepaid Expenses	0	0
8. Accounts Receivable-Owner/Related Party	0	0
9. Other (specify):	360,662	476,204
10. Total current assets	1,541,993	1,846,181
LONG TERM ASSETS		
11. Long-Term Notes Receivable	0	0
12. Long-Term Investments	0	0
13. Land	0	350,000
14. Buildings, at Historical Cost	0	5,265,179
15. Leasehold Improvements, Historical Cost	386,059	692,331
16. Equipment, at Historical Cost	408,427	1,064,124
17. Accumulated Depreciation (book methods)	-488,192	-1,540,407
18. Deferred Charges	0	0
19. Organization & Pre-Operating Costs	0	0
20. Accum Amort - Org/Pre-Op Costs	0	0
21. Restricted Funds	0	0
22. Other Long-Term Assets (specify):	0	147,908
23. other (specify):	0	0
24. Total Long-Term Assets	306,294	5,979,135
25. Total Assets	1,848,287	7,825,316
CURRENT LIABILITIES		
26. Accounts Payable	145,126	149,626
27. Officer's Accounts Payable	0	0
28. Accounts Payable-Patients Deposits	21,132	21,132
29. Short-Term Notes Payable	721,963	721,963
30. Accrued Salaries Payable	128,311	128,311
31. Accrued Taxes Payable	14,778	14,778
32. Accrued Real Estate Taxes	0	87,000
33. Accrued Interest Payable	0	108,748
34. Deferred Compensation	0	0
35. Federal and State Income Taxes	0	0
36. Other Current Liabilities (specify):	294,372	102,349
37. Other Current Liabilities (specify):	0	0
38. Total Current Liabilities	1,325,682	1,333,907
LONG TERM LIABILITES		
39.Long-Term Notes Payable	0	0
40.Mortgage Payable	0	6,583,462
41.Bonds Payable	0	0
42.Deferred Compensation	0	0
43.Other Long-Term Liabilities (specify):	0	0
44.Other Long-Term Liabilities (specify):	0	0
45.Total Long-Term Liabilities	0	6,583,462
46.Total Liabilities	1,325,682	7,917,369
47.Total Equity	522,605	-92,053
48.Total Liabilities and Equity	1,848,287	7,825,316

	Balance per Medicaid Trial Balance
1. Gross Revenue - All levels of Care	5,336,848
2. Discounts and Allowances for all Levels	0
Subtotal - Inpatient Care	5,336,848
4. Day Care	0
5. Other Care for Outpatients	0
6. Therapy	524,409
7. Oxygen	16,054
Subtotal - Ancillary Revenue	540,463
9. Payments for Education	0
10. Other Governmental Grants	0
11. Nurses Aide Training Reimbursements	0
12. Gift and Coffee Shop	0
13. Barber and Beauty Care	0
14. Non-Patient Meals	0
15. Telephone, Television, and Radio	0
16. Rental of Facility Space	0
17. Sale of Drugs	0
18. Sale of Supplies to Non-Patients	0
19. Laboratory	0
20. Radiology and X-Ray	0
21. Other Medical Services	0
22. Laundry	0
Subtotal - Other Operating Revenue	-
24. Contributions	0
25. Interest and Other Investments Income	14,692
Subtotal - Non-Operating Revenue	14,692
27. Other Revenue (specify):	797
28. Other Revenue (specify):	0
Subtotal - Other Revenue	797
30. Total Revenue	5,892,800
31. General Services	1,043,764
32. Health Care	2,374,612
33. General Administration	1,128,679
34. Ownership	862,766
35. Special Cost Centers	130,307
35. Provider Participation Fee	82,125
37. Other	0
40. Total Expenses	5,622,253
41. Income Before Income Taxes	270,547
42. Income Taxes	0
43. Net Income or Loss for the Year	270,547

Page

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
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Cost Report	
Line	Description
1	Dietary
2	Food Purchase
3	Housekeeping
4	Laundry
5	Heat & Other Utilities
6	Maintenance
8	TOTAL GENERAL SERVICES
10	Nursing & Medical Records
10A	Therapy
11	Activities
12	Social Services
16	TOTAL HEALTH CARE & PROGRAMS
17	Administration
19	Professional Services
21	Clerical & Gen. Office Expense
22	Employee Benefits & PR Taxes
24	Travel & Seminar
26	Insurance-Property, liability & Malpractice
28	TOTAL GENERAL ADMINISTRATIVE
29	TOTAL OPERATING EXPENSES
30	Depreciation
32	Interest
33	Real Estate Taxes
37	TOTAL OWNERSHIP
	TOTAL OPERATING & OWNERSHIP COST

Average Wage Data Table

Total staff hours including contract nurses per diem
Nursing hours including contract nurses per diem
RN
LPN
CNA
DON
ADON

2003 - Staffing and Occupancy Data

Average Occupancy
Medicaid Utilization
Medicare Utilization

State-Wide	HSA	HSA	HSA	HSA	HSA	HSA	HSA	HSA	HSA	HSA	HSA	HSA	HSA
	1	2	3	4	5	6	7	8	9	10	11		

State-Wide	HSA	HSA	HSA	HSA	HSA	HSA	HSA	HSA	HSA	HSA	HSA	HSA	HSA
	1	2	3	4	5	6	7	8	9	10	11		

State-Wide	HSA	HSA	HSA	HSA	HSA	HSA	HSA	HSA	HSA	HSA	HSA	HSA	HSA
	1	2	3	4	5	6	7	8	9	10	11		

Cost Report		Caseyville Nursing & Rehabilitation Center	Caseyville Nursing & Rehabilitation Center	2005 Census
Line	Description			47,659
1	Dietary			
2	Food Purchase			
3	Housekeeping			
4	Laundry			
5	Heat & Other Utilities			
6	Maintenance			
8	TOTAL GENERAL SERVICES			
10	Nursing & Medical Records			
10A	Therapy			
11	Activities			
12	Social Services			
16	TOTAL HEALTH CARE & PROGRAMS			
17	Administration			
19	Professional Services			
21	Clerical & Gen. Office Expense			
22	Employee Benefits & PR Taxes			
24	Travel & Seminar			
26	Insurance-Property, liability & Malpractice			
28	TOTAL GENERAL ADMINISTRATIVE			
29	TOTAL OPERATING EXPENSES			
30	Depreciation			
32	Interest			
33	Real Estate Taxes			
37	TOTAL OWNERSHIP			
	TOTAL OPERATING & OWNERSHIP COST			

LTC Median Per Diem Cost by HSA - 2004 Cost Reports
2004 (Run June 1, 2004)

UN-INFLATED

Cost	Description
1	Dietary
2	Food Purchase
3	Housekeeping
4	Laundry
5	Heat & Other Utilities
6	Maintenance
8	TOTAL GENERAL SERVICES
10	Nursing & Medical Records
10A	Therapy
11	Activities
12	Social Services
16	TOTAL HEALTH CARE & PROGRAMS
17	Administration
19	Professional Services
21	Clerical & Gen. Office Expense
22	Employee Benefits & PR Taxes
24	Travel & Seminar
26	Insurance-Property, liability & Malpractice
28	TOTAL GENERAL ADMINISTRATIVE
29	TOTAL OPERATING EXPENSES
32	Depreciation
32	Interest
33	Real Estate Taxes
37	TOTAL OWNERSHIP
	TOTAL OPERATING & OWNERSHIP COST

Caseyville
Nursing
&
Rehabilitation
Center
2004
Census

	State- Wide	HSA 1	HSA 2	HSA 3	HSA 4	HSA 5	HSA 6	HSA 7	HSA 8	HSA 9	HSA 10	HSA 11
Total staff hours including contract nurses per diem	5.00	5.30	5.30	5.30	5.30	5.10	4.80	4.80	4.80	5.10	5.30	5.20
Nursing hours including contract nurses per diem	3.00	3.20	3.20	3.30	3.20	3.10	2.80	2.80	2.80	3.10	3.20	3.10
RN	22.54	22.05	20.73	19.72	20.73	17.47	25.72	25.72	25.72	23.44	22.05	20.43
LPN	18.4	18.02	17.23	15.4	17.23	13.82	21.06	21.06	21.06	19.49	18.02	17.43
CNA	10.52	10.13	10.03	9.32	10.03	8.4	10.52	10.52	10.52	10.12	10.12	9.84
DON	28.97	27.38	25.17	23.86	25.17	22.23	34.39	34.39	34.39	30.41	27.38	25.97
ADON	25.23	23.95	21.85	19.41	21.85	19.13	28.74	28.74	28.74	26.68	23.95	23.77

	State- Wide	HSA 1	HSA 2	HSA 3	HSA 4	HSA 5	HSA 6	HSA 7	HSA 8	HSA 9	HSA 10	HSA 11
Average Occupancy	80.50%	80.70%	80.40%	78.10%	80.40%	74.40%	81.80%	81.80%	81.80%	82.90%	80.70%	78.20%
Medicare Utilization	65.00%	57.00%	56.70%	58.50%	56.70%	61.80%	70.60%	70.60%	70.60%	64.50%	57.00%	60.60%
Medicare Utilization	9.40%	7.70%	8.90%	9.30%	8.90%	8.80%	9.90%	9.90%	9.90%	13.00%	7.70%	8.90%

IDPA LTC Profiles
LTC Median Per Diem Cost by HSA - 2003 Cost Reports
2003 (Run June 1, 2004)

UN-INFLATED

Caseyville
Nursing &
Rehabilitation
Center
2003 Costs

2003
Census

Cost Report Line	Description	State-Wide	HSA 1	HSA 2	HSA 3	HSA 4	HSA 5	HSA 6	HSA 7	HSA 8	HSA 9	HSA 10	HSA 11	10th %	90th %
1	Dietary	6.10	7.02	6.48	5.50	6.48	5.48	6.06	6.06	6.06	5.60	7.02	5.70	4.13	9.81
2	Food Purchase	4.31	4.47	4.40	4.27	4.40	3.99	4.31	4.31	4.31	4.28	4.47	4.11	3.36	6.04
3	Housekeeping	3.70	3.59	3.68	2.91	3.68	3.40	4.05	4.05	4.05	3.97	3.59	3.61	2.48	5.80
4	Laundry	1.85	2.23	1.90	1.79	1.90	2.10	1.59	1.59	1.59	1.69	2.23	2.13	0.91	3.14
5	Heat & Other Utilities	2.95	3.17	2.93	2.94	2.93	2.71	2.93	2.93	2.93	2.91	3.17	2.95	2.05	4.25
6	Maintenance	3.01	3.26	3.03	2.99	3.03	2.55	3.21	3.21	3.21	3.05	3.26	2.82	1.92	5.12
8	TOTAL GENERAL SERVICES	22.58	24.49	22.99	21.14	22.99	21.47	22.65	22.65	22.65	22.45	24.49	21.73	17.57	31.51
10	Nursing & Medical Records	41.83	42.52	43.12	38.37	43.12	33.78	45.12	45.12	45.12	47.22	42.52	42.15	27.25	64.47
10A	Therapy	2.10	1.86	2.69	3.34	2.69	3.47	1.45	1.45	1.45	2.41	1.86	2.24	-	10.55
11	Activities	1.91	2.18	1.92	1.61	1.92	1.48	2.16	2.16	2.16	2.05	2.18	1.54	1.06	3.45
12	Social Services	1.42	1.45	1.64	1.05	1.64	1.09	1.60	1.60	1.60	1.12	1.45	1.27	0.58	3.00
16	TOTAL HEALTH CARE & PROGRAMS	49.48	50.39	51.22	46.39	51.22	41.58	52.34	52.34	52.34	54.96	50.39	49.49	32.10	77.23
17	Administration	3.36	3.33	3.15	3.15	3.15	3.60	3.46	3.46	3.46	3.04	3.33	3.17	1.71	7.21
19	Professional Services	0.99	1.09	0.85	0.83	0.85	0.76	1.12	1.12	1.12	1.13	1.09	0.77	0.07	3.44
21	Clerical & Gen. Office Expense	4.79	4.32	4.97	3.98	4.97	3.46	5.56	5.56	5.56	5.04	4.32	4.25	2.49	10.78
22	Employee Benefits & PR Taxes	10.09	10.42	11.01	8.88	11.01	7.67	10.51	10.51	10.51	11.38	10.42	9.08	6.33	19.34
24	Travel & Seminar	0.08	0.10	0.13	0.10	0.13	0.06	0.06	0.06	0.06	0.05	0.10	0.07	-	0.43
26	Insurance-Property, liability & Malpractice	2.58	2.47	2.55	2.35	2.55	2.22	2.85	2.85	2.85	2.19	2.47	2.61	0.88	4.32
28	TOTAL GENERAL ADMINISTRATIVE	24.94	25.31	26.11	23.02	26.11	21.37	25.81	25.81	25.81	26.59	25.31	22.93	16.95	39.14
29	TOTAL OPERATING EXPENSES	98.06	100.77	100.03	92.47	100.03	88.05	100.96	100.96	100.96	103.01	100.77	94.71	69.40	142.56
30	Depreciation	3.70	3.82	4.08	3.29	4.08	2.54	4.11	4.11	4.11	3.54	3.82	3.38	1.01	8.43
32	Interest	2.54	2.81	1.96	2.09	1.96	1.41	4.05	4.05	4.05	2.63	2.81	1.50	-	11.53
33	Real Estate Taxes	1.38	0.92	1.08	0.82	1.08	0.80	3.20	3.20	3.20	1.36	0.92	1.11	-	4.85
37	TOTAL OWNERSHIP	11.11	9.73	9.80	8.00	9.80	7.04	14.54	14.54	14.54	11.02	9.73	8.39	3.76	23.58
	TOTAL OPERATING & OWNERSHIP COST	109.17	110.50	109.83	100.47	109.83	95.09	115.50	115.50	115.50	114.03	110.50	103.10	73.16	166.14

Cost Report Line	Description	10th %	90th %
1	Dietary	4.13	9.81
2	Food Purchase	3.36	6.04
3	Housekeeping	2.48	5.80
4	Laundry	0.91	3.14
5	Heat & Other Utilities	2.05	4.25
6	Maintenance	1.92	5.12
8	TOTAL GENERAL SERVICES	17.57	31.51
10	Nursing & Medical Records	27.25	64.47
10A	Therapy	-	10.55
11	Activities	1.06	3.45
12	Social Services	0.58	3.00
16	TOTAL HEALTH CARE & PROGRAMS	32.10	77.23
17	Administration	1.71	7.21
19	Professional Services	0.07	3.44
21	Clerical & Gen. Office Expense	2.49	10.78
22	Employee Benefits & PR Taxes	6.33	19.34
24	Travel & Seminar	-	0.43
26	Insurance-Property, liability & Malpractice	0.88	4.32
28	TOTAL GENERAL ADMINISTRATIVE	16.95	39.14
29	TOTAL OPERATING EXPENSES	69.40	142.56
30	Depreciation	1.01	8.43
32	Interest	-	11.53
33	Real Estate Taxes	-	4.85
37	TOTAL OWNERSHIP	3.76	23.58
	TOTAL OPERATING & OWNERSHIP COST	73.16	166.14

Average Wage Data Table

State-Wide	HSA 1	HSA 2	HSA 3	HSA 4	HSA 5	HSA 6	HSA 7	HSA 8	HSA 9	HSA 10	HSA 11
Total staff hours including contract nurses per diem	5.10	5.30	5.30	5.00	5.30	5.10	4.90	4.90	4.90	5.10	5.30
Nursing hours including contract nurses per diem	2.90	3.20	3.10	3.10	3.10	3.00	2.70	2.70	2.70	3.00	3.10
RN	21.56	21.14	19.99	18.79	19.99	16.66	24.55	24.55	24.55	22.85	21.14
LPN	17.64	17.65	16.41	14.79	16.41	13.36	20.23	20.23	20.23	18.67	17.65
CNA	9.91	10.11	9.89	9.19	9.89	8.28	10.44	10.44	10.44	10.54	10.11
DON	27.82	26.67	24.49	23.07	24.49	20.82	33.29	33.29	33.29	29.65	26.67
ADON	24.39	22.67	21.12	19.67	21.12	18.73	27.45	27.45	27.45	26.14	22.50

2003 - Staffing and Occupancy Data

State-Wide	HSA 1	HSA 2	HSA 3	HSA 4	HSA 5	HSA 6	HSA 7	HSA 8	HSA 9	HSA 10	HSA 11
Average Occupancy	80.80%	80.80%	80.60%	79.90%	80.60%	75.20%	82.00%	82.00%	82.00%	81.60%	80.80%
Medicaid Utilization	64.80%	56.40%	57.70%	59.60%	57.70%	62.80%	70.00%	70.00%	70.00%	64.30%	56.40%
Medicare Utilization	8.50%	7.50%	7.50%	7.70%	7.50%	8.70%	9.10%	9.10%	9.10%	9.30%	7.50%

IDPA LTC Profiles
LTC Median Per Diem Cost by HSA - 2002 Cost Reports
2002 (Run June 1, 2004)

UN-INFLATED

Cost Report	State- Wide	HSA	HSA	HSA	HSA	HSA	HSA	HSA	HSA	HSA	HSA	HSA	10th %	90th %
Line	Description	1	2	3	4	5	6	7	8	9	10	11		
1	Dietary	6.01	7.28	6.51	5.36	6.51	5.48	5.92	5.92	5.83	7.28	5.60	4.17	9.77
2	Food Purchase	4.27	4.52	4.40	4.15	4.40	3.99	4.31	4.31	4.31	4.11	4.52	3.29	5.90
3	Housekeeping	3.65	3.84	3.56	3.05	3.56	3.25	4.13	4.13	3.89	3.84	3.48	2.51	5.63
4	Laundry	1.90	2.15	2.01	1.72	2.01	2.09	1.67	1.67	1.58	2.15	2.23	1.10	3.13
5	Heat & Other Utilities	2.71	2.84	2.76	2.75	2.76	2.54	2.67	2.67	2.72	2.84	2.73	1.89	4.03
6	Maintenance	2.99	3.41	2.96	2.91	2.96	2.48	3.16	3.16	2.90	3.41	2.92	1.95	5.11
8	TOTAL GENERAL SERVICES	22.09	24.39	22.49	20.85	22.49	20.47	22.71	22.71	22.66	24.39	22.04	17.19	30.80
10	Nursing & Medical Records	40.68	42.79	42.10	37.44	42.10	33.35	43.96	43.96	43.84	42.79	41.16	26.11	62.04
10A	Therapy	1.85	1.90	2.38	2.86	2.38	1.81	1.54	1.54	3.02	1.90	2.27	-	10.03
11	Activities	1.88	2.12	1.89	1.50	1.89	1.37	2.23	2.23	2.10	2.12	1.60	1.13	3.39
12	Social Services	1.44	1.46	1.50	1.08	1.50	1.13	1.61	1.61	1.32	1.46	1.32	0.58	3.00
16	TOTAL HEALTH CARE & PROGRAMS	47.55	50.19	49.32	44.36	49.32	39.56	50.57	50.57	52.75	50.19	47.76	31.31	74.79
17	Administration	3.39	3.49	3.30	3.27	3.30	3.61	3.39	3.39	3.20	3.49	3.54	1.65	6.84
19	Professional Services	0.98	1.00	0.76	0.88	0.76	0.98	1.05	1.05	1.05	1.19	1.00	0.07	2.93
21	Clerical & Gen. Office Expense	4.58	4.07	4.40	3.67	4.40	3.47	5.75	5.75	4.19	4.07	4.31	2.36	10.72
22	Employee Benefits & PR Taxes	9.63	10.11	10.26	8.28	10.26	7.80	10.26	10.26	9.30	10.11	8.44	6.22	17.51
24	Travel & Seminar	0.09	0.12	0.10	0.09	0.10	0.16	0.06	0.06	0.03	0.12	0.09	-	0.37
26	Insurance-Property, liability & Malpractice	2.19	1.93	1.97	1.87	1.97	2.00	2.46	2.46	2.40	1.93	2.03	0.83	3.92
28	TOTAL GENERAL ADMINISTRATIVE	23.47	23.64	24.80	21.32	24.80	20.28	25.17	25.17	23.10	23.64	21.93	16.13	36.02
29	TOTAL OPERATING EXPENSES	94.39	99.26	97.46	85.50	97.46	82.47	99.35	99.35	97.86	99.26	91.33	67.15	138.58
30	Depreciation	3.53	3.13	3.86	3.26	3.86	2.41	4.18	4.18	3.94	3.13	3.04	0.73	8.09
32	Interest	2.73	2.84	2.05	2.60	2.05	1.55	4.55	4.55	2.14	2.84	1.54	-	12.86
33	Real Estate Taxes	1.30	0.77	0.88	0.93	0.88	0.72	3.17	3.17	1.29	0.77	1.03	-	5.05
37	TOTAL OWNERSHIP	11.44	9.19	9.85	8.76	9.85	6.52	15.35	15.35	11.40	9.19	10.00	3.55	24.50
	TOTAL OPERATING & OWNERSHIP COST	105.83	108.45	107.31	94.26	107.31	88.99	114.70	114.70	109.26	108.45	101.30	70.70	163.08

Cost Report	2002 Costs	2002 Census
Line	Description	
1	Dietary	
2	Food Purchase	
3	Housekeeping	
4	Laundry	
5	Heat & Other Utilities	
6	Maintenance	
8	TOTAL GENERAL SERVICES	
10	Nursing & Medical Records	
10A	Therapy	
11	Activities	
12	Social Services	
16	TOTAL HEALTH CARE & PROGRAMS	
17	Administration	
19	Professional Services	
21	Clerical & Gen. Office Expense	
22	Employee Benefits & PR Taxes	
24	Travel & Seminar	
26	Insurance-Property, liability & Malpractice	
28	TOTAL GENERAL ADMINISTRATIVE	
29	TOTAL OPERATING EXPENSES	
30	Depreciation	
32	Interest	
33	Real Estate Taxes	
37	TOTAL OWNERSHIP	
	TOTAL OPERATING & OWNERSHIP COST	

2002 - Average Wage Data Table

State- Wide	HSA	HSA	HSA	HSA	HSA	HSA	HSA	HSA	HSA	HSA	HSA
	1	2	3	4	5	6	7	8	9	10	11
Total staff hours including contract nursing per diem	5.20	5.50	5.40	5.00	5.40	5.10	5.00	5.00	4.90	5.50	5.30
Nursing hours including contract nurses per diem	2.80	3.10	3.10	3.00	3.10	2.90	2.60	2.60	2.60	3.10	3.00
RN	20.69	20.12	19.18	18.37	19.18	16.06	23.49	23.49	23.49	21.31	19.45
LPN	16.89	17.04	15.72	14.33	15.72	12.75	19.39	19.39	19.39	17.96	15.69
CNA	9.73	10.05	9.65	9.09	9.65	8.08	10.28	10.28	10.28	10.39	10.05
DON	26.38	24.75	22.98	22.48	22.98	20.02	31.78	31.78	31.78	28.56	23.68
ADON	23.27	21.44	20.51	18.93	20.51	17.26	26.34	26.34	26.34	24.33	21.27

2002 - Staffing and Occupancy Data

State- Wide	HSA	HSA	HSA	HSA	HSA	HSA	HSA	HSA	HSA	HSA	HSA
	1	2	3	4	5	6	7	8	9	10	11
Average Occupancy	80.90%	79.60%	81.90%	80.30%	81.90%	75.30%	82.20%	82.20%	82.20%	79.60%	76.60%
Medicaid Utilization	64.50%	55.50%	56.10%	58.50%	56.10%	63.30%	69.90%	69.90%	66.70%	55.50%	60.90%
Medicare Utilization	7.40%	6.80%	7.20%	6.10%	7.20%	7.40%	7.70%	7.70%	8.20%	6.80%	7.00%